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ABSTRACT

This report is an assessment of the overall effectiveness of the Project Head Start Training and Technical Assistance Program (T/TA) in achieving Head Start objectives and improving program quality. Analysis in the report focuses on the overall management process, delivery system, quality of training and technical assistance provided, and its effects on the program. More than 1000 interviews were conducted with program directors, OCD personnel, community leaders, providers (medical consultants etc) and others, and their perceptions formed the basis of this report. A total of 30 programs were selected as volunteers for on-site programs. Methodology is described in detail, and findings and conclusions are presented under the following headings: Head Start Objectives and Policy and Guidance (at the national and regional level); Need Assessment and T/TA planning, Provider Selection, Control of Providers, Evaluation of T/TA, Satisfaction with T/TA, T/TA Resources Utilized, Effects of T/TA, Excellence of T/TA, Target groups, Content Categories (social services at the national, regional and local level); and supportive resources and special categories such as nutrition and psychological services (at the local level). Also included is a section on direct funding. Many tables are included. (MS)

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KIRSCHNER ASSOCIATES, INC.

ED127030

FINAL REPORT

Volume I

TO EVALUATE THE OVERALL EFFECTIVENESS OF PROJECT HEAD START TRAINING AND TECHNICAL ASSISTANCE PROGRAMS (NATIONALLY)

Contract No. HEW-105-74-1112

December 31, 1975

Charles J. Clinton
Project Director

Barbara Clem Barrett
Field Supervisor

WASHINGTON, D.C.

PS 008740

rque New Mexico 87106 / 2425 Alamo Avenue, S.E. / (505) 243-1763

Washington, D.C. 20005 / 733 15th Street, N.W. / (202) 638-3423

PREFACE

This study was undertaken from July 1974 to September 1975 by Kirschner Associates, Inc. for the Office of Child Development, Department of Health, Education, and Welfare, Washington, D.C., under Contract No. HEW-105-74-1112 (formerly HEW-OS-74-246). The purpose of the project was to assess the overall effectiveness of the Project Head Start Training and Technical Assistance (T/TA) Program.

ACKNOWLEDGEMENTS

Kirschner Associates, Inc, would like to acknowledge the assistance and cooperation of the many staff members of the Office of Child Development who contributed to the completion of this Final Report. In particular, we are indebted to Ms. Barbara Bates of the Research and Evaluation division, who served as Project Officer for the entire duration of this study, and to Mr. Joseph Montoya and Mr. Edward Clark of the Career Development and Technical Assistance division, who provided help from their perspective as managers of the overall T/TA program of Project Head Start.

Many other members of OCD staffs at both the national and regional levels were also most helpful by consenting to lengthy interviews. We are indebted to them for being most generous with their time and thoughts. The same is true for many local program people and numerous T/TA providers who consented to interviews by our staff. Since all of these various interviewees total nearly 1,000, it obviously would not be possible (nor appropriate) to mention them individually, but their generous cooperation was critical to this evaluation.

This project was performed with the able assistance of various consultants who regularly provided valuable direction and guidance. They were:

Dr. Richard Benjamin
Dr. George Bricker
Dr. Geraldene Felton
Dr. Carol Rubow Foster
Mrs. Erika Landberg
Dr. Betty Ruano
Mrs. June Sale
Dr. Carol Seefeldt

Field work was conducted principally by university-affiliated professionals located in the vicinity of the local program sites where research for this study was undertaken. The Field Research Associates (FRAs) involved were the following:

Field Research Associates

Dr. Walter Baeumler
Mr. Alfred Betts
Ms. Florence B. Bonner
Ms. Ann Camelio
Mr. Paul J. Caruso
Dr. C. Daniel Fisher
Ms. Dolly A. Hanbrick
Dr. Wilma Hepker
Mr. Emory Hubbard
Dr. Christopher Lindley
Mr. Larry Logan
Dr. Theodore E. Long
Ms. Marie L. Mandrake
Dr. Robert E. Maroney
Mr. Ralph O. Marshall
Ms. Jean D. Mazer
Ms. Janet Mulka
Mr. Joseph C. Noone
Mr. Charles O. Patillo
Mr. Marvin J. Price
Ms. Helen S. Reager
Ms. Marjorie S. Rogasner
Ms. Barbara Schoenberg
Dr. Edmund J. Sheerin
Mr. Conner W. Shepherd
Mr. Arlen M. Sjerven
Mr. Samuel Sylvester
Ms. Ruth Uhlmann
Mr. J. Steven Welsh
Mr. Roger White
Ms. Annie Williams
Dr. William J. Wilson
Mr. Gerald D. Wright

All of these persons cited, individually and collectively, were most helpful in this project. However, the central project staff of Kirschner Associates, Inc. were responsible for the conduct of this eyaluation as well as for the data analysis and resultant findings and conclusions that are the subject of this Final Report. The Project Administrator was Mr. Alan Pittaway, the Project Director was Mr. Charles Clinton, and the Field Supervisor, Ms. Barbara Clem Barrett. In addition, substantive direction to the project was provided by Mr. Jack Dickerson, Vice President of KAI, in charge of the firm's Washington, D.C. office and Ms. Barbara Casey Ruffino, a senior associate

of the firm located in Boston, Massachusetts, who served as Project Director during the early phases of the effort.

Other KAI professional staff who were of assistance include: Ms. Andy Adler, Ms. Lorrie Kaitz, Mr. Richard Mantovani, Ms. Fran Oscar, Mr. Morris Peterson, Mr. Merle Van Dyke, and Ms. Norma Wise. Each of these persons made a significant contribution to the total task. Two other individuals were hired by KAI to prepare the data for computer processing Ms. Betty Bailey and Mr. Charles Ayres. Without their efforts, the overall project could not have been completed. Lastly, the secretarial staff of KAI deserves a great deal of credit for their painstaking work: Ms. Laurie Effers, Ms. Sue Cary, Ms. Earlene Chen, Mr. Dewey Childs, Ms. Yvonne Eades, Ms. Van Kennedy Ms. Marty Kipps, Ms. Mary McAdams and Ms. Joann Parker.

TABLE OF CONTENTS

EXECUTIVE SUMMARY — See Volume II

LIST OF EXHIBITS — xi

GLOSSARY — ff. xi

I. INTRODUCTION — 1
a. Descriptive Setting — 1
b. Purpose of the Project — 2

II. METHODOLOGY — 7
a. Overview — 7
b. Assumptions and Limitations — 8
c. Selection Criteria and Process — 12
d. Instrumentation — 46
e. Data Analysis Plan — 47
f. Problems Encountered — 49

TABLE READING GUIDE — ff. 51

III. FINDINGS AND CONCLUSIONS — 52

MANAGEMENT OF T/TA — 52

M1 HEAD START OBJECTIVES — 53
a. National Level — 53
b. Regional Level — 59

SUMMATION — 62

M2 POLICY AND GUIDANCE — 65
a. National Level — 65
b. Regional Level — 67

SUMMATION — 69

M3 NEED ASSESSMENT AND T/TA PLANNING 71
a. National Level 71
b. Regional Level 85
c. Local Level 132

SUMMATION 183

M4 PROVIDER SELECTION 187
a. National Level 187
b. Regional Level 192
c. Local Level 205

SUMMATION 212

M5 CONTROL OF PROVIDERS 215
a. National Level 215
b. Regional Level 220
c. Local Level 237

SUMMATION 243

M6 EVALUATION OF T/TA 247
a. National Level 247
b. Regional Level 250
c. Local Level 259

SUMMATION 267

DELIVERY OF T/TA 270

D1 SATISFACTION WITH T/TA 270
a. National Level 271
b. Regional Level 272
c. Local Level 276

SUMMATION 282

D2	T/TA RESOURCES UTILIZED	283
	a. National Level	283
	b. Regional Level	290
	c. Local Level	314
	SUMMATION	339
D3	SUPPPORTIVE RESOURCES	343
	c. Local Level	343
	SUMMATION	
D4	TARGET GROUPS	365
	a. National Level	365
	b. Regional Level	368
	c. Local Level	378
	SUMMATION	391
D5	CONTENT CATEGORIES	395
	a. National Level	395
	b. Regional Level	399
	c. Local Level	408
	SUMMATION	426
D6	SPECIAL CATEGORIES	429
	c. Local Level	429
	SUMMATION	
	EXCELLENCE OF T/TA	451
E1	Quality of T/TA	453
	a. National Level	453
	b. Regional Level	455
	c. Local Level	465
	SUMMATION	490

E2 EFFECTS OF T/TA 495
a. National Level 495
b. Regional Level 500
c. Local Level 519

SUMMATION 553

SPECIAL SECTION

DF Direct Funding 557

SUMMATION 565

IV. RECOMMENDATIONS 567

LIST OF EXHIBITS

Exhibit I	KAI Technical Panel	13
Exhibit II	National Office Staff Interviews Completed	16
Exhibit III	Percent of 70 Head Start Directors Utilizing Each National Provider Organization	18
Exhibit IV	Regional Office Staff Interviews Completed	20
Exhibit V	RTO/STO/STATO/OICS Interviews completed	25
Exhibit VI	Characteristics of 70 Head Start Programs in Telephone Sample Utilized to Select 30 Programs in On-Site Sample	33
Exhibit VII	Factors Involved in Setting of Head Start Objectives at National Level	53
Exhibit VIII	Interaction of Participants in Process of Formulation of Head Start Objectives	55
Exhibit IX	The Objective Setting Process	ff. 56
Exhibit X	Common Factors in Devising T/TA Plans at the Regional Level	ff. 91

GLOSSARY OF TERMS

ACRONYMS

AAPW	American Academy of Pediatrics
AMA	American Medical Association
a-v	audio-visual
CDA	Child Development Associate
CDTA	Career Development and Technical Assistance Division
CEC	Council for Exceptional Children
CFRP	Child and Family Resource Program
CL	Community Leader
CR	Community Representative
DHEW	Department of Health, Education, and Welfare
DK	Don't Know
DSP	Director, Staff and Parents
ERIC	Educational Resources
FRA	Field Research Associates
FY	Fiscal Year
HEW	Health, Education and Welfare
HQ	Headquarters
HS	Head Start
HSST	Head Start Supplementary Training
I&I	Improvement and Innovation
IMPD	Indian and Migrant Program Division
LDP	Leadership Development Program
LP	Local Program
MBO	Management by Objectives
MEDC	Migrant Educational Development Center
MIS	Management Information System
NA	Not Applicable
NO	National Office
OCD	Office of Child Development
OICS	Office of Indian Child Services
PA	Program Account
PA20	T/TA Account in Budget
PAC	Policy Advisory Council
PD&I	Program Development and Innovation Division
PI	Parent Involvement
PMD	Program Management Division
PR&R	Program Review and Resource Specialist
RO	Regional Office
RPD	Region Program Director
RSD	Regional Support Division
RTO	Regional Training Office (r)
SEDL	Southwest Educational Development Laboratory
STATO	State Technical Assistance and Training Office (r)
STO	State Training Office (r)
Sup'CR	Supervisory Committee Representative
TADS	Technical Assistance Development System
T/TA	Training and Technical Assistance
USDA	Department of Agriculture
USPHS	Public Health Service

OTHER TERMS

Dir	Director
direct-funding	PA20 money made available to local grantees to purchase their own T/TA directly
Div	Division
"norm"	see Reader's Guide to Understanding Tables in Chapter III
n	number of respondents
OCD Director	Either OCD Headquarters or OCD Regional Office Director
positive	"Excellent, very good, & good" parts of five-point scale
very positive	"Excellent and very good" parts of five-point scale

Chapter I: Introduction

This Final Report has been prepared for the Office of Child Development in order to provide them with a comprehensive accounting of the conduct and results of KAI's project to evaluate Head Start Training and Technical Assistance activities. It is divided into four chpaters:

Chapter I	-	Introduction
Chapter II.	-	Methodology
Chapter III	-	Findings and Conclusions
Chapter IV	-	Recommendations

This introductory Chapter contains two sections, one on the descriptive setting of the project and another on the purposes of the project.

A. DESCRIPTIVE SETTING OF THE PROJECT

Project Head Start began in 1965 and in the past decade has played, in the words of the fourth Head Start Director, James Robinson, "a major role in focusing the attention of the nation on the importance of early childhood development; it has served as a model for many other programs; it has pioneered in the delivery of health services; it has had a major impact on community efforts on behalf of low-income families, and perhaps above all, it has demonstrated the vitally important role that parents play in the early years of their children's development."

Today approximately 1300 local grantees serve over one third of a million children, including many with handicaps, in nearly 10,000 centers located throughout the country. These centers depend upon almost 70,000 professional or para-professional personnel and approximately 95,000 volunteers to carry our their mandate to enable children of poverty to become socially competent.

A budget of over $400 million dollars annually is allocated to the Department of Health, Education, and Welfare for the Office of Child Development which administers Project Head Start. Of this amount of money, approximately $20 million was set aside in FY75 for Head Start Training and Technical Assistance Programs. OCD Headquarters spends about one-fourth

of this sum ($4.8 million), the eleven Regional Officers receive the other three-fourths ($14.3 million). One part of this regional money ($4.1 million) subsidizes the Head Start Supplementary Training/Child Development Associate (HSST/CDA) programs which serve to provide academic credentially opportunities for parents and staff. The remainder ($10.2 million) is used by the regions to fund all their other T/TA efforts. This could mean funding regional providers, e.g., Regional Training Officers (or their counter-parts) or private consultants, etc., or distributing monies directly to local programs to enable the grantee to purchase its own T/TA

In FY 75 the National Office decided to spend part of its $4.8 million budget to conduct an evaluation of the total T/TA system (excluding the HSST/CDA programs) operated by Project Head Start. The focus of the evaluation was to be on the management, delivery, and excellence of T/TA; the scope was to include the national, regional, and local levels. No study had yet been undertaken of this kind or dimension during the first decade of Head Start's existence. No concerted and comprehensive effort had ever been made to evaluate how much value Head Start was receiving for its annual investment of nearly $20 million for training and technical assistance activities. Hence this project was funded. (HEW Contract 144-74-HEW-OS.)

Kirschner Associates Inc., hopes this report contains the kind of data, i.e., findings, conclusions, and recommendations, that will benefit Project Head Start and facilitate its efforts to expand and improve its various T/TA activities.

B. PURPOSE OF THE PROJECT

The purpose of this project was to assess the overall effectiveness of the Project Head Start Training and Technical Assistance Program (T&TA) in assisting national and regional office staff and Head Start grantees in achieving Head Start objectives and improving program quality. KAI has examined the various components of the T&TA system at the national, regional, and local levels. Our analysis in this report focuses on the overall management process, delivery system, quality of training and technical assistance provided, and its effects on the program.

The study was to address three major questions:

1. How effective is Headquarters in the formulation of policy, management and guidance for the Regions and in the management and utilization of its own T&TA resources?

   Assessment of the Headquarters role encompasses:

   - determination of the effectiveness of OCD Headquarters in formulating and communicating policy and guidance related to the Head Start T&TA.
   - determination of the extent to which the needs assessment function is being performed in relation to filling gaps and serving special national needs on an efficient basis.
   - determination of the extent to which Headquarters is meeting its own goals in providing training and technical assistance with a particular focus on the delivery system structure and management of the system.

2. Are the Regions providing effective leadership and management that results in the delivery of appropriate, high quality T&TA that accomplishes the purposes for which it is intended?

   Some of the areas being covered in the assessment of the role of the Regional Office, its relationship to local grantees and the overall effectiveness of its T&TA system are:

   - procedures for determining T&TA needs (regional and local)
   - local assessment of T&TA needs and its effectiveness
   - procedures for evaluating and monitoring of T&TA grants
   - alternatives available for local grantees concerning T&TA
   - overall management system including planning, perceived and actual local needs, T&TA provider selection process, fiscal and administrative control of T&TA delivery, and monitoring and evaluation procedures for services delivered.

3. Is the T&TA provided appropriate and if so, of sufficient quality to accomplish its intended purpose?

The following areas were to be investigated:

- intended purposes of designated T&TA as related to actual needs of grantees
- appropriate use of available T&TA
- alternative forms of T&TA available
- delivery of T&TA and effectiveness of various system components
- quality of T&TA and effectiveness of various system components
- quality of T&TA delivered to local grantee in relationship to effectiveness of T&TA provided as perceived by the local grantee recipients.
- relationship of T/TA to national, regional and local objectives

These basic questions were refined and condensed in order a) to facilitate the conduct of the evaluation and b) to make it easier for the reader to abstract the results of the study presented in this report. All of the questions and subquestions were regrouped according to three major subjects:

- o Management of T/TA
- o Delivery of T/TA
- o Excellence of T/TA

Then all the questions and subquestions were further organized according to topic under each of the three main subjects. Care was exercised throughout to ensure that every important question was included and well-integrated into this basic topical format.

The results of this process can be seen on the following page.

Statement of Purpose of the Project
(in terms of T/TA topics & questions)

M. Management of T/TA

M1. Are appropriate and effective Head Start objectives formulated?

M2. Is appropriate and effective policy and guidance developed?

M3. Are appropriate and effective processes followed to assess needs and devise T/TA plans accordingly?

M4. Is an appropriate and effective T/TA provider selection process in place?

M5. Are appropriate and effective quality controls exercised, e.g., reporting and monitoring?

M6. Is an appropriate and effective evaluation system being implemented?

D. Delivery of T/TA

D1. How satisfied are the consumers with T/TA dollars available?

D2. How effectively are resources used in T/TA service delivery?

D3. How effectively are other supportive resources being utilized?

D4. How equitably is T/TA distributed among target groups?

D5. How effectively are content areas being covered?

D6. How effectively are special content areas, i.e., nutrition, psychological services, and handicapped needs, being addressed?

E. Excellence of T/TA

E1. Is the T/TA of high quality?

E2. What effects does the T/TA bring about?

Special Section

DF. Are there advantages to directly-funding local programs so that they can purchase their own T/TA?

One other related questions surfaced, "What are the advantages of direct-funding local programs so that they can purchase their own T/TA services." Hence, this issue was added on to be above list of items that constitute the purpose of the project.

This topical arrangement greatly aided KAI staff in the conduct of the study, as it permitted the integration of like issues across the various levels under analysis. It is hoped that this topical arrangement will also aid the reader. For example, it should facilitate the task of OCD HQ executives in studying all aspects of T/Ta at the regional, national and local levels. It should also make it convenient for a Regional Office staff person to study only the regional level aspects of T/TA.

Chapter II: Methodology

A. OVERVIEW

This project was undertaken during the period from July 1974 to September 1975. Described in the previous chapter were the main T/TA subjects and the various topical questions under each that constituted the purpose and scope of the study. A brief synopsis of the evaluation methodology was given in that chapter to help orient the reader. What this Chapter will present is a detailed explanation of all facets of the methodology employed, including such things as certain assumptions and limitations that impacted the conduct of the study, sample criteria, and selection, instrumentation, data analysis, and problems encountered.

Since this study was geared to addressing the three main T/TA subjects of management, delivery, and excellence in comprehensive coverage at the national, regional, and local levels, some preliminary remarks are in order on the interrelationships involved.

1. Management of T/TA

The primary emphasis in the data collection effort on this subject was at the national and regional levels. That is why key officials were interviewed on-site at OCD HQ, the ten geographic regional offices, and IMPD. With two topics, the setting of H.S. objectives and the devising of policy and guidance, it seemed appropriate to probe only with these two levels of respondents and not with local level respondents. With the other topics, needs assessment provider selection, provider control, and evaluation of T/TA, it seemed appropiate to survey not only national and regional level respondents but local level ones as well. In all cases an attempt was made to ask identical or compatible questions on the different levels. The scope and depth of questioning was tailored to the level of respondent as much as possible.

2. Delivery of T/TA

As it happens T/TA is delivered to Head Start at all three levels and so questions on this subject were addressed to interviewees at each level. However, the emphasis was placed largely on the local level, given the fact that

a great deal of the total T/TA package available to Project Head Start is aimed at local grantees. At all levels the topics addressed were satisfaction with T/TA dollars available, T/TA resources utilized, other supportive resources, target groups, and content categories of T/TA. However, as with the subject of management, questions asked were varied somewhat depending on the level and category of respondent.

3. Excellence of T/TA

Excellence consists of two aspects: quality of T/TA and effects of T/TA and was stressed mostly at the local program level, since it is there that the bulk of all T/TA is received. Questions on the subject, as with management and delivery, were geared to the level and category of respondent.

B. ASSUMPTIONS AND LIMITATIONS OF THE PROJECT

There were several assumptions or limitations that constrained the conduct of this evaluation. We would like to discuss each of them briefly before going further into this report.

A necessary background for this discussion is a preliminary overview here of the project methodology. The basic methodology of this evaluation was the analysis of information gathered on the Head Start T/TA program at the national, regional and local levels from both H.S. staff and T/TA providers. This strategy was employed because it was deemed essential for the study to have the most inclusive data sources and to enable the identification of differential perceptions, attitudes, and knowledge between and among the levels.

Information-gathering efforts and voluminous data centered around the three major T/TA subjects discussed earlier in Chapter I: Management of T/TA; Delivery of T/TA; and Excellence of T/TA (in terms of both quality and effect).

1. RESPONDENTS' PERCEPTIONS ARE IN LARGE PART THE BASIS ON WHICH THIS REPORT IS BUILT

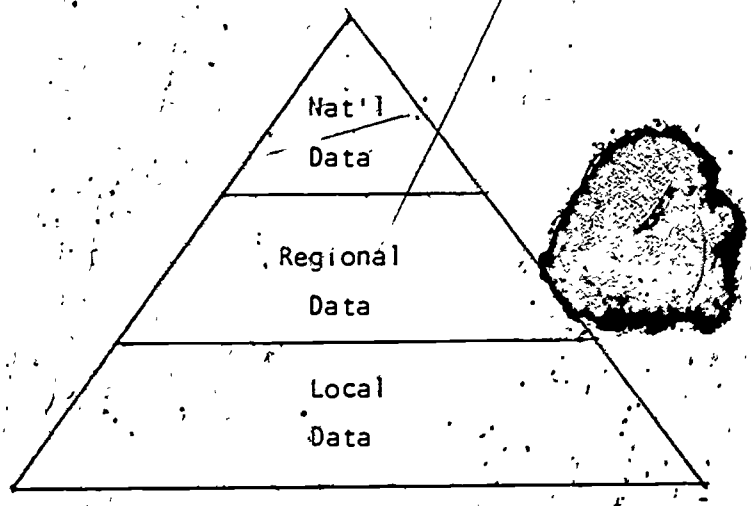
KAI conducted nearly 1,000 personal interviews during this 15 month project. We also read numerous policy statements from OCD HQ, and T/TA annual plans from the Regional Offices, local program T/TA plans, and many other related resource documents. These have all been taken into account to the extent possible. However, the bulk of the findings and conclusions contained in this report represent the results of interviews with selected respondents. Any interviewee will have certain biases; no interviewer can overcome or weed out such biases. They exist and must be kept in mind, especially because this study is an evaluation of the Head Start T/TA program primarily based on perceptions of those respondents chosen to be part of the study.

Specifically this becomes an issue when trying to determine how much effect T/TA is having. Just because, hypothetically, 98% of all those interviewed report that T/TA is having a great effect doesn't guarantee that such is the case. KAI realized this and tried to devise checks and balances throughout the project that would ultimately result in a truer picture of the reality of T/TA. Nonetheless, this area is one in which complete success can never be achieved, and presents a limitation which, to some extent, constrains this evaluation.

2. RESPONDENTS AT DIFFERENT LEVELS WILL HAVE DIFFERENT PERCEPTIONS OF T/TA

Another assumption, related to the previous one, is that OCD HQ personnel, for example, will have a different perspective on T/TA than, say, staff involved in a local program. Because Head Start's T/TA program is nationwide and operative at the national, regional, and local levels, and because of the nature of the study design (i.e., requesting information on the same three major topic areas from dissimilar study sub-groups), it was expected that divergent viewpoints, attitudes, perceptions, and levels of familiarity would be projected in the data. Thus, it was expected that certain limitations would have to be imposed in the extent to which study results could be generalized.

The amount and completeness of the data varies inversely with the levels within which data was gathered. Graphically, our expectations for the quantity of data productions would be pictured as follows:



One such limiting dimension is simply restricted knowledge or information on the part of respondents, and lack of opportunity/necessity to have certain knowledge. For example, respondents at the national level, as expected, generally were relatively unaware of operational specifics of T/TA service at the local program level. Likewise, local program personnel appeared to be knowledgeable of national office functioning only in a most tangential manner.

3. DIFFERENTIAL ROLE FUNCTIONS OF RESPONDENTS PRODUCE VARYING RANGES OF DATA

As is usual with evaluation techniques utilizing interview survey methods, resultant data frequently does not yield definitive information throughout the entire range of specific and relevant dimensions of the evaluation/study process. A primary constraint in the data analysis process seems most related to the differential role functions and patterns of different interviewees within each of the three levels (national, regional, local) surveyed. It was expected that an individual interviewee, of course, would provide more complete information in response to those interview questions which most closely approximated his own specific areas of responsibility and functioning.

Thus, it was expected that a financial officer could provide considerable data on item areas concerned with the budget or dollar allocations to various units; however, it was not expected that such an interviewee would be able to contribute a great deal on program planning, implementation, or evaluation processes. Likewise, project officers for selected T/TA activities might not be able to provide complete information on the needs assessment activities and processes at the local or even the regional levels. Thus, for any individual interviewee it was expected that the study would obtain a restricted range of data.

Consequently, the data is regarded to represent thoughts, opinions, or information (depending on the nature of the item area) which yield some trends and tendencies on the various evaluation dimensions rather than firm and definitive concensus information. To that end we urge considerable caution in determining conclusions on issues for which data was available only from a limited number of personnel.

4. THE LENGTH OF THE LOCAL PROGRAM INTERVIEW MAY HAVE AFFECTED THE DATA RECEIVED AT THAT LEVEL

There was some initial concern by KAI staff over the length of the Interview Survey Form designed for use with local level personnel. The primary objective for the use of the instrument was to gather the most comprehensive and inclusive data possible; meeting this objective necessarily resulted in an extensive time requirement from each interviewee. Specific concern, then, was over the possible factors of bordom, fatigue, and item irrelevancy for some respondents. Our subsequent experience in the administration of the instrument with individual respondents proved our initial concerns to be unfounded for the most part. Interviewers reported some instances in which they perceived the data to be affected by item irrelevancy, primarily for some parents interviewed.

5. RESISTANCE FROM SOME RESPONDENTS TO BEING INTERVIEWED WAS EXPECTED TO SOME DEGREE

Likewise, in a study of this magnitude it was anticipated that resistance to respond in the interview situation might be encountered in some quarters for various reasons. Although this phenomena was not observed by KAI interviewers to any significant degree, the actual strength of this factor on data results remains unknown.

6. BECAUSE THE STUDY EXTENDED OVER 15 MONTHS, PROGRAM AND POLITICAL CHANGES MAY HAVE OCCURRED WHICH WOULD AFFECT THE RESULTS OF THE EVALUATION

KAI has remained aware that, to a large extent, our efforts were a study of processes in which change is likely to occur over time -- or even during the life of this evaluation contract. When we have been appraised of changes which have occurred since our data gathering period we have made appropriate data adjustments. However, the possibility remains that unreported changes have transpired -- in fact, it would seem likely that the conduction of this study itself has prompted certain change producing actions particularly at local and regional levels which are not reflected in this study.

KAI was also acutely attuned to the fact that varying changing political determinants and organizational structures -- particularly as they are operative at regional and local levels -- would carry the probability of differential responses on various items and issues. Included here would be those postures of vested interests which directly affect the nature of the information provided. Thus it was anticipated that in certain cases respondents would provide data or information which would be in the best interests of the respondent, and consequently might not be reflective of an actual situation. It is impossible to ascertain completely the degree to which this phenomenon has been reflected in the data.

C. DEVELOPMENT OF SELECTION CRITERIA AND IMPLEMENTATION OF SELECTION PROCESS

KAI staff received assistance from several sources in the development of selection criteria and implementation of the selection process. This help came from the Project Officer, OCD personnel, and KAI's Technical Panel. The latter group was structured to assist us in the development of approaches to the content of data needed, the sample selection, and the data analysis. The Technical Panel members constituted a group of experts in study design, methodology, analysis, evaluation, and knowledge of Head Start programs and training and technical assistance activities. (See Exhibit I for panel membership.)

EXHIBIT I

KIRSCHNER ASSOCIATES, INC. TECHNICAL PANEL

HS/T/TA EVALUATION CONTRACT

1. Dr. Richard Benjamin
Lansing Public Schools
Lansing, Michigan
(Evaluation)

2. Dr. George B. Bricker
Washington, D.C.
(Management and Evaluation)

3. Dr. Geraldene Felton
Walter Reed Army Institute of Research
Washington, D.C.
(Research and Evaluation)

4. Dr. Carol Rubow Foster
Decatur, Georgia
(Evaluation and Training and Technical Assistance)

5. Mrs. Erika Landberg
Washington, D.C.
(Program and Community Development)

6. Dr. Betty Ruano
Baltimore, Maryland
(Research and Evaluation)

7. Mrs. June Sale
Los Angeles, California
(Program and Training and Technical Assistance)

8. Dr. Carol Seefeldt
Millersville, Maryland
(Child Development and Technical Assistance)

The criteria were selected from a number of alternatives studied by KAI staff and the Technical Panel. The criteria as they are presented in this methodology section are ranked by relative importance; however, in some instances the criteria are in fact co-equal. The ranking of the criteria was done through the use of a "Comparator". The "Comparator" is a device designed to allow respondents to rank each criterion with every other criterion individually. In this way, all criteria were matched by a minimum of 12 persons (Three KAI staff and nine Technical Panel members). From these 12 sets of rankings, the relative rank for each criterion was then calculated. In this fashion it was possible to derive a list of criteria, ranked usually in order of importance, for each sample group.

The Comparator was used as an aid to arrive at the necessary criteria for choosing interviewees at the national, regional, and local levels. What follows next is an explanation of both the development and then the application of the selection criteria at each level.

1. National Level

a. OCD HQ Personnel - After early discussions with the Project Officer and the Chief of the Career Development and Technical Assistance (CDTA) Division, a list of appropriate personnel to interview at OCD Headquarters was evolved. These personnel were recommended because of their familiarity with and/or involvement in T/TA activities. They included staff in OCD from CDTA and the Program Management Division (PMD), the director of Head Start, staff from the Program Development and Innovation (PD&I) Division, from the Child Development Services Bureau, from the Regional Support Division (RSD), and from the Grants and Contracts and Financial Management Divisions of the Office of Administration and Management. (See Exhibit II for display of interviewees.)

A total of 24 staff were interviewed in person individually at Headquarters. As has been mentioned before, the questions asked of these respondents were extremely comprehensive and were differentially administered. That is, not all respondents were asked all questions, because their functions and knowledge varied. At the onset of each interview a determination was made about which questions to ask the respondent based on the nature of that individual's expertise. Unless contradictory information was revealed during the interview, the areas of questioning followed the original plan. These interviews averaged 90 minutes in length.

It is germane at this point to explain briefly that two project staff conducted all interviews at the national and regional office levels. By confining the number of interviewers to these two, inter-reliability of interview techniques and approaches were increased and conflicting or confusing responses among

respondents were more readily probed to ensure more accurate and comprehensive information.

NATIONAL OFFICE STAFF INTERVIEWS COMPLETED — Exhibit II

H.Q.	DIRECTOR	EXEC. ASS'T	GRANTS MAN.	PROG. ANALYSIS	SPECIALISTS	TOTAL
OHD						
OAM		INF.				1
Grants and Contracts			1.			1
Gen. Serv.						
Budget and Finan. Man.						
Finan. Man.	1					1
OCD						
RSD	1			3		4
CB						
CDSB		1				1
Head Start	1					1
PMD				2		2
CDTA	1			6		7
(IMPD)*						
PD&I	1				5	6
	5	2	1	11	5	24

* Counted in R.O. Table

INF.= INFORMAL DISCUSSION

INTERVIEWS COMPLETED (KAI T/TA EVALUATION)

b. National T/TA Providers

The criteria for selecting national providers (funded from Program Account 20 monies) were developed by KAI staff and the Technical Panel. The Comparator was used to establish a rank order. In order to establish a link between case study regions and local programs where on-site interviews were conducted and to have a representative group of providers across type of organization, range of dollars, and kind of T/TA given, the following criteria were used to select providers:

1. Operative in all case study regions;*
2. Includes largest contract for T/TA;
3. Represents mix of type of provider organization (university, agency, private corporation).

Using documents and information from CDTA staff, a comprehensive list was drawn up to all T/TA expenditures for FY 1974 and 1975. Those providers who gave services in some form (direct services, materials, etc.) to our case study regions were identified. According to our information, the providers so identified included not only organizations with the largest T/TA budgets but also some with the smallest (the range was over $1 million to $31,000). Various types of provider organizations were represented as well.

Then a list of these providers was included in the telephone interviews conducted with Head Start directors in the seven case study regions in order to determine level of services delivered by these providers to local programs. From this list of 15 providers, 10 were selected for interviewing based on the frequency of responses from these Head Start director interviews. (See Exhibit III for a list of the 15 with the frequencies of positive response as regards utilization.)

*An explanation of what is meant by "case study regions" will be given in the regional level section (2b) which follows next.

EXHIBIT III

Percent of 70 Head Start Directors Utilizing Each National Provider Organization

National Providers Selected for Inclusion in the Director Telephone Interview	Percent of Directors Indicating Utilization of Each Provider Organization
American Academy of Pediatrics	71.4 *
United States Public Health Service	30.0 *
American Psychological Association	14.3 *
American Dietetic Association	4.3 *
Council for Exceptional Children	17.1 *
Technical Assistance Development System	2.9 *
Communication Research Lab	0.0
Modern Talking Pictures	31.4
Educational Research Information Center	32.9 *
Inter-American Research Association	2.9
High Scope Foundation	12.9 *
CDA Consortium	40.0
UNIDOS Management Association	0.0
Social Dynamics	14.3 *
Transcendental Corporation	1.4

* Selected for telephone interview

The national provider interviews were conducted by telephone. For reasons which will be explained in the Problems Encountered section of the Methodology discussion, only nine national provider organizations were finally available for the conduct of interviews. A total of 34 staff members in these nine organizations were interviewed via telephone for approximately 45 minutes each. These interviews were conducted by trained interviewers from the KAI office staff.

The makeup of positions that these national providers held in regard to T/TA activities was:

Directors (of organization or project)	9
Assistant Directors (of organization or project)	3
Psychology/Mental Health Consultants	6
HSST/CDA/ Education Consultant	1
Private Consultants	3
Health/Nurse/Nutritionist Coordinators	4
Education Coordinator	1
Information Specialists	2
Total	34

2. Regional Level

a. Regional Office Personnel

In concert with CDTA and RSD Headquarters personnel, a list of key regional staff in each Regional Office was drawn up. As with Headquarters staff, those persons were chosen because of their familiarity with and/or involvement in T/TA activities in the region. Once in a Regional Office, our interviewer expanded the core list with other personnel recommended by the OCD Director or his designated contact. Those people interviewed generally included the OCD Director (although not in every instance); the PR&R Specialist (or those persons with the equivalent functions); Supervisory Community Representatives; Community Representatives; Component Specialists; and Grants Management Specialist. Sixty-four (64) regional office personnel were interviewed using the regional office interview guidelines. (See Exhibit IV for display of the number and function of respondents in each region.) Not all respondents were asked all questions, due to the differing job functions and knowledge of each person. As with the Headquarters personnel, the same two interviewers conducted these personal interviews in the regions. The average length of time per interview was 90 minutes.

KIRSCHNER ASSOCIATES, INC.

REGIONAL OFFICE STAFF INTERVIEWS COMPLETED

Personnel \ Region	I	II	III	IV	V	VI	VII	VIII	IX	X	IHPD
Assistant Regional Director			INF.		INF.	INF.					
Assistant Assistant Regional Director								INF.			
Regional Program Director	1	1	1	1*	1	1*	1	1	1	1	1
Deputy Regional Program Director				1*							
Program Review and Resource Specialist	1	1	1	1		1		1	1	1	1
Program Operation	1				1		INF.			1	
Supervisory Community Representative			1	1*	1				1		
Community Representative	1	2			3	1	1	2	1	2	2
(Area Coordinator)											2
Program Inspector						1					
SPECIALISTS:											
Parent Involvement/ Social Services								1	1		
Child Development				1				1		1	
Mental Health/ Career Development								1			
Head Start Supplementary Training									1		
Grants Management (OHD)		1				1	1	1	1		
Program Development (OHD)				INF.		1	1				
SUBTOTAL; Interviews	4	5	3	5	4	6	5	7	7	6	6
Informal			1	1	1	1	1	1			
Total	4	5	3	6	5	7	6	8	7	6	6

b. Case Study Regions

As our proposal stated, the case study approach was chosen because it was not possible, within the scope of this effort, to structure a survey sample representative of the entire system. The case study regions comprise a variety of systems models which encompass the range of significant characterisitcs of the existing T/TA systems. In evolving this purposive sample of regions, KAI staff and the Technical Panel developed a set of criteria to assist in the selection task. Through the use of the Comparator, these general selection criteria for the case study regions were finally chosen:

1) Includes a distribution of several types (national, regional, direct) and a number of T/TA providers.
2) Includes largest and smallest regional office T/TA budgets
3) Representative of other non-selected regions
4) Representative geographically/cross section of population
5) Includes regions with State and Regional Training Offices
6) Includes regions with autonomy from Headquarters (as evidenced by development of own instruments, guidance, etc.)
7) Includes regions with competitive bidding for selecting providers.

Some of these criteria made part of the selection process relatively easy, e.g., Region IV has the largest T/TA budget. There were other considerations that made it desirable for inclusion, however, and they will be presented shortly. Through careful use of these criteria, the selection of the case study regions was made. (It should be noted that originally only five regions were selected, but during the project the contract was expanded and extended to permit the inclusion of two additional regions.)

Based on the general criteria just listed, the staff of Kirschner Associates, Inc. selected seven case study regions. The following is a listing of the regions selected along with the specific criteria used as a basis in each instance. IMPD was preselected by terms of the contract.

Region II

1) mix of state, regional, and directly funded providers
2) RTO system
3) average amount of T/TA dollars
4) urban/rural mix
5) racial/ethnic mix
6) northeast location
7) development of own assessment tools.

Region III

1) unique provider system with the existence of the Regional Resource and Training Center
2) STO system and directly-funded providers
3) average amount of T/TA dollars
4) urban/rural mix
5) racial/ethnic mix

Region IV

1) mix of state and multi-state providers
2) STO system
3) direct-funded programs have been defunded
4) highest amount of T/TA dollars
5) southeast location
6) urban/rural mix
7) racial/ethnic mix

Region V

1) mix of regional and state providers
2) existence of directly-funded programs
3) high amount of T/TA dollars
4) north/midwest location
5) change in provider system
6) urban/rural mix
7) racial/ethnic mix

Region VI

1) state providers only except for Leadership Development Program (LDP)
2) largest number of T/TA grants
3) middle range of T/TA dollars
4) racial/ethnic mix (black, Spanish-speaking)
5) south/midwest location
6) development of own assessment tools and guidance documents
7) computerized system of aggregating data from local programs

Region X

1) unique provider system with centralized administration of T/TA dollars through one state office
2) states tend to set their own priorities
3) low range of T/TA dollars
4) northwest localtion

c. Regional Providers

1) Group 1

Regional Training Office (RTO)/State Training Office (STO)/ State Technical Assistance and Training Office (STATO)/Office of Indian Child Services (OICS)/Migrant Educational Development Center (MEDC) Personnel

RTO/STO/STATO/OICS/MEDC staff were chosen in all regions for interviewing to gather information about the T/TA management and delivery

systems. At the time the interviews were conducted, there were approximately 73 such offices in all regions (with staff ranging from one to four or five people, in some instances). Our criteria for choosing officers from this list were two: one, geographic representation across the states in Regions II - X and across the areas served by IMPD, and two, the most senior, experienced officer in the state or IMPD area. Each regional T/TA specialist was contacted to determine which officer would qualify. Three factors influencing the final selection should be mentioned. Since Region I has a system of State Training Centers with a variety of consultants providing T/TA, it constituted a variation from the conventional RTO/STO/STATO/OICS/MEDC network and was not included in the survey. A second factor was that, in a few instances, the most senior person was not available, so another experienced officer was substituted. A third factor affecting the selection process was that, in some instances, a training office serves two states. Thus, for these reasons, plus non-availability of a few respondents, not all states are represented in this sample. (See Exhibit V, following this page).

A total of 42 training officers were interviewed via telephone by trained KAI interviewers. The average length of interview was 45 minutes.

2) Group 2

State, multi-state and region-wide provider organizations and representatives of the RTO/STO/STATO/OICS/MEDC network.

A variety of regionally-funded providers were also selected for telephone interviewing. The primary criterion for their selection was that each provider serve the local program where the on-site interviews were being conducted. This information was known through the local program interviews discussed in the following section. The following criteria were met, if not totally (#6 being the exception) in each case study region, then across all case study regions.

EXHIBIT V

RTO/STO/STATO/OICS INTERVIEWS COMPLETED

REGION	STATE
II (RTO)	New York New Jersey
III (STO)	Washington, D.C. Maryland Pennsylvania Virginia West Virginia
IV (STO)	Alabama Flordia Georgia Kentucky Mississippi North Carolina South Carolina Tennessee
V (RTO)	Illinois Indiana Michigan Minnesota Ohio Wisconsin
VI (RTO)	Arkansas Louisana New Mexico Oklahoma Texas
VII (STM)	Iowa Kansas Missouri Nebraska
VIII (STO)	Montana South Dakota Utah

REGION	STATE
IX (RTO)	Arizona California Hawaii
X (RTO)	Idaho Washington Oregon
XI (OICS)	Minnesota Arizona Texas

1. Provider to site where program interviews are conducted
2. Includes largest contract/grant for T/TA
3. Provides comprehensive (as opposed to specialist) T/TA
4. Represents balance of serving management, staff, and parents
5. Includes providers with varying modes of evaluation
6. Represents mix of type of provider (university, agency, private corporation)

The process for determining which providers were interviewed consisted of using the data from the director telephone and on-site interviews at the local program. Our interviewer at the local program site would confirm the names and functions with KAI central staff and then conduct the interview (s) with the appropriate provider staff.

The size of the grants or contracts to these provider groups ranged from $7,350 to $465,400. The number of interviews in a particular office ranged from one to five depending on the size and availability of the staff. Across all case study regions 77 regional providers were interviewed for approximately 45 minutes each. These providers included personnel from state T/TA grantees, LDP, HSST, CDA, and organizations serving region-wide as well as the representatives of the RTO/STO/STATO/OICS/MEDC network. The positions that these regional providers held in regard to T/TA activities were categorized as follows:

Director (RTO/STO/STATO/OICS/MEDC)	22
Assistant Director or Officer (RTO/STO/STATO/OICS/MEDC)	22
Teacher trainer	1
Administration/Fiscal Services	1
Program/Planning Manager	10
Executive Director or Supervisor	6
Health Coordinator	1
Education Coordinator	3
Parent Involvement Coordinator	1
Special Services Coordinator	4
HSST/CDA/Education Consultant	2
Private Consultant	1
Secretary/Fiscal Assistant	3
Total	77

3. Local Level

a. Local Programs

In order to conduct interviews at the local program level, the proposal called for the selection of ten programs in each case study region. From this initial group of ten programs, four programs were to be chosen for on-site interviews. The criteria developed by KAI staff and the Technical Panel for the selection of the ten programs in each case study region follows:

1) Amount of Head Start grant money (High - Medium - Low)
2) Geographically representative
3) Size of Program (Large - Medium - Small)
4) 50 selected as a group are representative of the others not selected
5) Largest of providers of T/TA are represented
6) Urban or rural location
7) Rate of turnover of staff/children
8) Basis of acceptance of local T/TA plan by RO
9) Status of Grantee (Agency/School)
10) Funding increases or decreases

As the exploratory work to accomplish the selection of these 70 programs went on, KAI staff discovered that several of the criteria (#7, 8, 9, and 10) could be utilized only if extensive and arduous consultation with Regional Office staff was maintained. This procedure was judged to be inadequate for several reasons. One, it required too much time from Regional Office staff; second, the information sought was not available in all Regional Offices in readily collectable form; and third, such a procedure subjected the sample selection to possible bias. Therefore, project staff chose another avenue for getting the information needed.

The selection of local programs was initiated by utilizing the resources of the Division of Financial Operations and Fiscal Procedures in the Department of Health, Education, and Welfare. That division maintains a microfiche record of all grantees receiving monies distributed through the DHEW. Using their microfiche records, and a publication called Financial Assistance by Geographic Area, Fiscal Year 1974, DHEW (Publication No. (OS) 74-12), put out by the Office of the Assistant Secretary, Comptroller, Deputy Assistant Secretary, Finance, Division of Financial and Management Reporting, a master list of all Head Start programs in every county in each state was compiled for the case study regions. This master list included the amount of each Head Start program's grant. Because two primary criteria, the amount of Head Start grant money and geographic location, were established for selecting the programs in the sample, the programs were ordered within each state in each case study region by amount of Head Start grant, ranked from lowest to highest amount.* There were two exceptions to the use of these records. One was for Region II. An examination of microfiche and the Region II publication revealed that not all programs were listed. Therefore, a request was made to the Region II OCD for a complete list of programs and the list was immediately forwarded to us. The second exception was for the Indian and Migrant Program Division. In the records these programs were included within each state rather than as a separate region. Our request for a complete list of IMPD programs was promptly met and we drew our sample of IMPD programs from it. It was necessary to be sure that these IMPD programs were excluded from all listings in the other regions. This step was carefully followed in drawing up the list for each state.

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* Three jurisdictions were excluded. Puerto Rico in Region II and Alaska in Region X because we did not intend to go to those two areas for the on-site interviews, Delaware in Region III, because it had only four Head Start grantees and the total monies in other states in the region were several times greater.

Once the list of programs in each state (and IMPD area) in a region had been developed, six programs in each state (and IMPD area) were selected for inclusion on a second list. These six programs included two in the low range of Head Start grant money, two in the middle range, and two in the high range. Once this second list had been evolved for each state (and IMPD area) in the region, an initial purposive sample of ten programs in the region was drawn. The basis for selecting the ten was to have representation across all three levels of grant money amount (low, medium, and high) and geographic representation. We should mention that we usually chose to select one more program in the middle or high range than in the low. We felt that given the limited number of programs in our sample our best use of the time and money expended for interviewing would be with those programs with larger numbers of staff, parents, and community leaders.

In deciding how many programs from each state (or IMPD area) would be chosen for inclusion on the list of ten programs, the number finally selected depended first, on the number of states in a region, and second, the total amount of Head Start monies present in each state. For example, in Region IV there are eight states. With a total of ten programs needed, the sample was drawn to have at least one program from each state to ensure geographic representation. In looking at the total amount of Head Start grant money in each state, it was found that the state of Mississippi had over $300 million in grants, while all the other states ranged from approximately $6 million to just over $12 million in grant money. Therefore, three programs were chosen from the state of Mississippi and the other seven from each of the remaining seven states. This formula, picking the number of programs in each state (and IMPD area) in proportion to the amount of Head Start money, was utilized throughout the selection of programs in each region.

After the sample of ten programs in each region had been drawn, contact with the Regional Office PR&R Specialist (or the person with equivalent functions) was made. The purpose of this contact was to

apprise the Regional Office of our initial sample, check to ascertain whether any exclusively summer programs had been included, and to determine if there was any overriding condition present in any of the programs chosen which would make it impossible potentially to conduct an on-site visit (e.g., intensive management and/or programmatic evaluation which required successive visits by Regional Office or other personnel that would conflict with the time frame for our visit; internal program reorganization or disputes which would negatively affect our data collection; or inaccessibility, such as a two-day horseback trip.) In some instances, a substitution was necessary in our initial sample of ten. When this substitution had to be made, an alternate from our second sample was drawn, keeping within the criteria of amount of Head Start grant money and geographic representation.

It should be noted that, had any regional office attempted to swing the selection toward a better program by suggesting that the original program had problems, this hypothetical bias would tend to favor our findings, not detract. The results from our study on a number of key variables show surprising negative variations from the presumed norm. Thus, if we have somewhat better than average programs in our sample, it means that results are more positive than those that would have come from "average" or "below average" programs. And concern about the more "normal" conditions would be increased, not decreased. As a general rule, regional office personnel were most cooperative and appreciative of maintaining the integrity of our sample. We had to rely on their information once the initial sample had been drawn according to our criteria and, for the most part, have no cause to presume selection bias. We are satisfied that our final sample of selected programs met the critical criteria; regional office check-off was an addendum. Once this final sample was in place, the actual telephone interviews could be begun. Every selected program was sent a letter informing them of their selection, the intent of the study, the method by which they had been chosen, the purpose of the telephone interview, general content of the questions, and requesting their cooperation in the telephone interviews. All program directors consented to participate in the telephone interview. In

toto, 70 program directors were interviewed across the seven case study regions by trained interviewers from the KAI office.

In order to select the final number of local programs where on-site interviews were to be conducted, the telephone questionnaire for Head Start directors was designed to give information on most of those criteria to be utilized in that final selection. The criteria for this selection were:

1) Amount of money (High - Medium - Low)
2) Degree of director's satisfaction (High - Low) with T/TA received
3) Utilization of large cross-section of providers
4) Size of program (Large - Medium - Small)
5) Distribution of T/TA dollars vis-a-vis
   - management/administrators
   - teachers
   - parents
   - support staff
6) Largest of providers of T/TA are represented
7) Geographically representative
8) Cross-section of staff (i.e. no unusually organized programs)
9) Final check-off by CR and/or PR&R of 30 selected(based on Directors' responses).
10) Urban or rural location

The questions included in the director telephone interview asked for statistical information about the number of children served; number of different staff members; total program and T/TA budget; type of grantee agency; percent of T/TA received from each source (national, regional, and directly-funded providers, and non-Head Start free resources); ranking of T/TA received by administrators, teachers, parents, support staff; satisfaction/dissatisfaction with T/TA received; and impact of

T/TA. From the responses given by the director, the final selection of programs for on-site interviews was made, based on incorporating programs reflective of the range and frequency of responses in the telephone interviews. (See Exhibit VI for matrix showing key criteria for each program in the 70 sampled which were utilized to select the final 30.)

Every program director was asked if he/she had any objections to an on-site visit. Out of the 70 directors interviewed, 5 said they did have objections, and three or more said they did not, but that that answer was given with reservations. The objections were primarily because the program staff was extremely overloaded with proposal-writing and grant-application activities. In one instance the director stated that internal reorganization of T/TA services was creating such instability that a visit would be counterproductive to the purposes of our study. All programs whose directors indicated objections to an on-site visit were eliminated from consideration of the final sample. The rationale for this procedure was based on the contractor's belief that efforts to interview local program personnel required a substantial block of time from program personnel, and if those personnel were not available, were too busy to give proper attention to the requirements of the interview, or were uncooperative, the information gleaned would be inaccurate and negatively skew the data base.

A total of 30 programs were chosen for on-site interviews. As a validation of our sample, we divided these programs selected for on-site interviews (i.e., the 30 who comprised the final local program sample) from those interviewed via telephone only (i.e., those 40 who were not included in the final local program sample) and made a computer run with this split on every variable in the telephone interview. Since most of the criteria utilized for the selection of these final 30 programs were incorporated in the telephone interview, this validation would indicate the presence of any biases.

Characteristics of 70 Head Start Programs in Telephone Sample Utilized to Select 30 Programs In On-Site Sample

EXHIBIT VI

	Budget		Direct Funded		# of Children Served	# of Centers Served	Type of Area Served		# of Staff		Percent of T/TA Provided by Type of Provider					Ranking of T/TA Amount				Level of Satisfaction			T/TA Impact				Effect to On-site visit
	General	T/TA	Yes	No					Full Time	Part Time	Nat	Reg	Loc	Non OCD	Staff	Director	Teacher/Aide	Support Staff	Parents	Very Satis	Satisfied	Dissatis.	A great deal	Quite a bit	Some	A Little	
* 1.	3,800,000	34,000	✓		2,000	56	✓	✓	352	7	5	45	45	5		4	1	3	2		✓		✓				
* 2.	2,939,815	+		✓	2,100	68	✓		380		15	15		70		4	3	2	1		✓		✓				
* 3.	2,747,002			✓	1,563	36	✓	✓	352	15	5	15		20	60	1	2	3	4		✓			✓			
* 4.	2,321,200	54,151	✓		1,615	93		✓	392		Information			Unknown		4	1	2	3		✓			✓			
5.	2,091,744			✓	965	24	✓		Unknown		25	75				4	2	3	1		✓			✓			
* 6.	2,011,129	27,086		✓	1,750	42	✓		185	18	5	80		15		3	1	4	2		✓		✓				
7.	1,770,559	6,500		✓	800	15	✓	✓	141	9		30		70		2	1	3	2		✓		✓				
* 8.	1,707,709			✓	1,420	26	✓	✓	322		5	80		15		3	1	2	1		✓		✓				
9.	1,672,503	5,752		✓	1,431	48	✓		200	89	15	25		60		3	1	4	2		✓		✓				
* 10.	1,600,000	42,000		✓	958	14	✓	✓	179		1	10	10	79		2	1	3	4		✓		✓				
11.	1,600,000	35,000		✓	1,157	34	✓	✓	268		2	2	50	46		4	1	3	2		✓		✓				✓
* 12.	1,467,713			✓	824	17	✓		184	1	1	40		59		2	1	4	3	✓					✓		
13.	1,313,870	4,425	✓		850	22	✓		147	12	3.3	3.3	3.3	90		2	1	4	3		✓			✓			
14.	1,275,609			✓	767	16	✓		113		10	70		20		3	1	4	2		✓		✓				✓

Characteristics of 70 Head Start Programs in Telephone Sample Utilized to Select 30 Programs in On-Site Sample

EXHIBIT VI

	Budget		Direct Funded		# of Children Served	# of Centers Served	Type of Area	# of Staff		Percent of T/TA Provided by Type of Provider					Ranking of T/TA Amount				Level of Satisfaction			T/TA Impact				Subject to on-site visit
	General	T/TA	Yes	No				Full Time	Part Time	Nat	Reg	Loc	Non OCD	Staff	Director	Teacher/Aide	Support Staff	Parents	Very Satisfied	Satisfied	Dissatisfied	A great deal	Quite a bit	Some	Little	
* 15.	1,104,663	6,200	✓		940	25		✓ 207		10	15	5		70	3	1	2	1			✓			✓		
* 16.	938,691			✓	437	7	✓	✓ 105	7	10	60		30		3	2	4	1	✓			✓				
17.	857,742			✓	1,220	8	✓	✓ 133		2	78		20		1	3	4	2			✓	✓				
18.	682,082	3,500		✓	624	7		✓ 134		25	50		25		2	1	1	3		✓		✓				
19.	658,982			✓	620	11	✓	✓ 107			35		65		1	1	2	2		✓			✓			
20.	490,492		✓		323	9	✓	✓ 101	19	5	10	65	20		2	1	3	4		✓			✓			
* 21.	454,490	7,290	✓		405	10		✓ 100	3	3	25	50	22		1	3	2	4	✓			✓				
22.	451,901	350		✓	375	6	✓	77	5	3	50		47		4	1	2	3		✓			✓			
* 23.	447,961			✓	180	7		✓ 64		2	30		10	68	4	1	3	2		✓			✓			
24.	371,790	7,357		✓	240	8	✓	44		5	90		5		4	1	3	2	✓			✓				
* 25.	367,876	3,978	✓		293	11	✓	✓ 65	4		40	50	10		4	1	3	2		✓		✓				
* 26.	361,646	4,000	✓		288	11	✓	✓ 50		15	70	15			3	1	1	2		✓			✓			
* 27.	345,333			✓	361	6	✓	✓ 37	14	20	65		15		2	1	3	4	✓				✓			
* 28.	306,620	18,217		✓	45	3	✓	✓ 28	1	2	8		90		2	1	3	4			✓		✓			

* Chosen for on-site sample.

EXHIBIT VI

Characteristics of 70 Head Start Programs in Telephone Sample Utilized to Select 30 Programs in On-Site Sample

	Budget		Direct Funded		# of Children Served	# of Centers Served	Type of Area Served	# of Staff		Percent of T/TA Provided by Type of Provider					Ranking of T/TA Amount				Level of Satisfaction		T/TA Impact			Subject to on-site visit
	General	T/TA	Yes	No				Full Time	Part Time	Nat	Reg	Loc	Non OCD	Staff	Director	Teacher/Aide	Support Staff	Parents	Very Satisfied	Dissatis.	A great deal	Quite a bit	Little	
* 29.	306,440			✓	380	20		49	4	10	80		10		2	1	3	4	✓		✓			
30.	283,618			✓	234	8	✓	38	15	40	55		5		3	1	4	2	✓			✓		
31.	280,084		✓		660	10	✓	81	Un-known	45	30		25		4	1	3	2	✓		✓			
* 32.	270,000	939		✓	155	8	✓	25	14	5	80		15		2	1	3	4		✓		✓		
33.	250,000	400		✓	225	7		25	29	3	50	3	44		1	2	4	3		✓	✓			
34.	243,100	3,400	✓		180	7		36		10	20	50	20		2	1	3	4	✓			✓		✓
35.	241,301			✓	125	5	✓	27	6	5	55		40		2	1	4	3		✓		✓		
36.	236,600	5,000	✓		215	3		27		1	98	1			2	1	3	4		✓		✓		✓
* 37.	185,500	400		✓	140	3		30	8	10	50	15	25		2	1	4	3		✓	✓			
* 38.	177,000	Info. Unknown		✓	120	4		1	31	1	60	9	30		3	1	4	2		✓		✓		
39.	171,768	3,500	✓		191	7		24	8	2	20	15	63		3	1	4	2	✓		✓			
* 40.	171,596	500		✓	140	5		20	12	5	15	5	75		2	1	1	3	✓		✓			
* 41.	156,818	3,500		✓	120	6		49		5	5			90	4	1	3	2		✓			✓	
42.	136,821	1,501		✓	75	2		15	4	2	28		70		2	1	4	3		✓		✓		

* Chosen for on-site sample

Characteristics of 70 Head Start Programs in Telephone Sample Utilized to Select 30 Programs in On-Site Sample

EXHIBIT VI

	Budget		Direct Funded		# of Children Served	# of Centers Served	Type of Area		# of Staff		Percent of T/TA Provided by Type of Provider					Ranking of T/TA Amount				Level of Satisfaction		T/TA Impact			Subject to on-site visit
	General	T/TA	Yes	No			Urban	Rural	Full Time	Part Time	Nat	Req	Loc	Non OCD	Staff	Director	Teacher/Aide	Support Staff	Parents	Very Satisfied	Dissatis.	A great deal	Quite a bit	Some	A Little	
43.	132,000	7,000	✓		134	9	✓	✓	66	4	30	40	10	20		2	1	4	3	✓				✓		
44.	130,395			✓	84	4	✓	✓	1	20	1	10		89		2	1	4	3	✓			✓			
45.	128,000	2,000	✓		128	5	✓	✓	19	6	1	80	2	17		3	1	4	2	✓			✓			
46.	124,883	1,300		✓	106	3		✓	2	17	20	60		20		1	2	4	3	✓			✓			
* 47.	116,058		✓		109	2	✓	✓	16	5	10	20	50	20		3	1	4	2	✓			✓			
48.	111,089	7,025	✓		110	1		✓	20			50	25	25		1	2	3	4	✓		✓				✓
* 49.	108,080	2,138		✓	60	4	✓	✓		16	5	60	5	30		3	1	4	2	✓		✓				
* 50.	103,920	1,000		✓	60	2		✓	11	3	5	90		5		4	1	2	3	✓		✓				
* 51.	99,000	7,250	✓		85	2		✓	16	6	5	90	2.5	2.5		2	1	3	4	✓		✓				
* 52.	83,500	200		✓	45	2		✓	8	5	5	5		90		2	1	3	4		✓				✓	
53.	82,700	500	✓		65	1		✓	13	2	Information Unknown					1	2	3	4	Information Unknown						
54.	78,720	600		✓	60	4		✓	11	9		10		90		2	1	3	4		✓		✓			
* 55.	71,924	550	✓		67	4		✓	11	3	25	25	25	25		2	1	2	2	✓			✓			
56.	65,747	1,069	✓		60	4		✓	11	6	NO T/TA					2	1	0	0	Information Not Applicable						

*Chosen for on-site sample.

Characteristics of 70 Head Start Programs in Telephone Sample Utilized to Select 30 Programs in On-Site Sample

EXHIBIT VI

	Budget		Direct Funded		# of Children Served	# of Centers Served	Type of Area		# of Staff		Percent of T/TA Provided by Type of Provider					Ranking of T/TA Amount				Level of Satisfaction			T/TA Impact				Subject to on-site visit
	General	T/TA	Yes	No			Urban	Rural	Full Time	Part Time	Nat	Reg	Loc	Non OCD	Staff	Director	Teacher/Aide	Support Staff	Parents	Very Satisfied	Satisfied	Dissatis.	A great deal	Quite a bit	Some	A Little	
57.	64,750	700		✓	45	2		✓	4	4	10	30		60		1	2	4	3	✓			✓				
58.	63,650			✓	51	1		✓	2	38	5	40	15	40		4	1	3	2		✓			✓			
59.	62,000			✓	30	1	✓	✓	9	1		50		50		2	1	3	4			✓			✓		
60.	60,000	430		✓	60	3		✓	9		5	40	55			2	1	3	2		✓		✓				
61.	53,099			✓	40	1		✓	11		25	65		10		4	1	3	2	✓			✓				
62.	44,923			✓	40	2		✓	13	12	25	50		25		2	1	4	3		✓			✓			
63.	42,491			✓	30	1		✓	6	2	5	60		35		2	1	3	4		✓				✓		
64.	42,100	900		✓	44	1		✓	7		49	49		2		1	2	4	3			✓		✓			
65.	40,408			✓	36	1		✓	4	7		45		55		3	1	4	2	✓				✓			
66.	40,000			✓	30	1		✓	5	3	Get Some	33.3	Get Some	33.3		4	1	2	3		✓			✓			
67.	38,540			✓	30	1		✓	4	2	1	60		39		3	2	4	1		✓			✓			
68.	37,328	900	✓		40	2		✓	5		10	15	25	50		3	1	4	2	✓			✓				
69.	30,530	1,100	✓		30	2		✓	4	2	10	20	40	30		2	1	4	3	✓			✓				
70.	28,300	500	✓		20	1		✓	4	1	7.5	60	2.5	7.5		2	1	3	4	✓				✓			

One one of the six variables showing statistically significant variations between the two groups is worth noting, and that is population size.

Population Size	On-Site Sample	Telephone Contact Only
Below 2,500	0	5
2,500 to 10,000	3	6
10,000 to 50,000	6	14
50,000 to 250,000	13	4
Over 250,000	6	10
Combination of two or more sizes	2	1
TOTAL	30	40

It can be seen that representation from cities under 50,000 and over 250,000 population is lower in our on-site sample than in the telephone sample. As has been mentioned, we chose one or two more programs with middle or high amount of program dollars (depending on the region's total amount of program dollars) than with low amount of program dollars in each region. Programs with larger budgets would generally reflect larger child enrollment, more likely found in urbanized areas. So this distribution of on-site programs according to population size is not unexpected.

(The other variables in this group of six included several relating to number of full- and part-time personnel. The fact that 14 programs in our on-site sample had from one to nine full-time bus drivers compared to 20 programs in the telephone-contact-only group, or that five programs in the on-site sample had only one part-time administrator compared to thirteen programs in the telephone-contact-only group, reveals at most that our on-site programs tended to be larger in size than smaller. This selection was purposive.)

Since none of these variables in and of themselves were critical, and in fact were for the most part irrelevant (given the type of variable and the variation from the "norm"), our sample of on-site programs measures up very well against the criteria developed for the purposes of this study.

b. Local Program Personnel

At the local program level several categories of respondents were interviewed. Those categories of respondents included the director, staff, parents, and community leaders. The director(s) at each program were initially selected on the basis of having been interviewed by telephone as part of the sample of 70. On-site, some of these directors recommended that other directors (e.g., of delegate agency, individual program or center) also be interviewed. When appropriate, this procedure was employed.

The criteria for selecting staff and parents were as follows. In each program, if a choice of respondents was available because the total number was large, people who had familiarity and experience with T/TA activities were selected from among the staff, parents and community leader groups. We wanted as many respondents as possible who had been recipients of T/TA within the three categories of respondents, these people were to be chosen:

1) Staff

   a) Coordinators (or Specialists)
      - Education
      - Social Services
      - Parent Involvement
      - Career Development
      - Health (including nutrition)

   b) Teachers

In those programs where the minimum number of coordinators and teachers receiving T/TA did not total five to seven, teachers' aides and support staff who had received T/TA were concluded in the staff category.

2) Parents

This category of respondents included parents of Head Start children who are active in the program as a:

a) Policy Advisory Council Member
b) Teacher Aide
c) Volunteer

These respondents could not duplicate those selected from the staff category.

3) Community Leaders

This category of respondents varied considerably, but generally it included leaders who were active in the program as a:

a) Grantee Agency or Board Member
b) Policy Advisory Council Member
c) Community Agency Person

These people could serve in an agency that actually provided services to the local program. The criterion for their selection was familiarity with the T/TA given to the program.

The categories and number of the 428 director, staff, and parent respondents interviewed are:

1) Administrators

Executive and Head Start Directors for Grantee or Delegate Agency	38
Head Start Directors for Center	6
Field Coordinators/Supervisors	12
Administration/Finance/Personnel Directors	6
Other (e.g., Assistant Head Start Director)	5
	67

2) Staff

Component Coordinators	
Education	17
Parent Involvement/Volunteer	9
Social/Family Services	17
Career Development	5
Health	15
Handicapped	3
Nutrition	5
Mental Health	2
Medical	1
Dental	1
Assistants in One of Above Components	4
	79
Teachers	
Lead/Master Teachers	23
Teachers	50
Teacher Aides	29
Teacher/Coordinator Combination	4
	106
Support Staff	
Nurses	3
Cooks	6
Bookeepers	1
Clerical	1
Combination within Staff Categories	1
	12

3) Parents

Policy/Parent Advisory Council/ Committee Membership	61
Teacher Aides	9
Volunteer	30
Combination within above Parent Categories	7
Combination Parent/Staff Categories	20
Parent Only	37
	164
Grand Total	428

You will note that, for the most part, these interviewees had a high degree of involvement in the program. Since familiarity and experience with T/TA activities were primary criteria for their selection, they constitute a valid sample for the purposes of this study. While it is true that some respondents in each category were not knowledgeable about some topics (e.g., T/TA planning and needs assessment processes, provider selection, or percent of T/TA from each provider type), overall this sample group provides reliable and valid data.

Among community leaders, the number and categories of the 162 respondents are:-

School Superintendents and Principals	5
School Teachers	5
Directors/Administrators/Supervisors of Grantee, Agency, or Resource Organization	78
Social Workers	11
Nurses	6
Psychologists	2
Medical Doctors	3
Secretaries/Clerks	5
Specialists	
Curriculum Development	1
Early Childhood Education/Development	5
Health	4
Nutrition	2
Student Placement	3
Other	9
Others (Tribal/School/County Board Members, Ministers, Red Cross workers, etc.)	23
Grand Total	162

All interviews at one site were conducted by a trained KAI field interviewer who lived in or near the program site. The interviewer made telephone contact with the director to get a list of people to be interviewed and set up appointments before going on-site.

Our field interviewers were drawn from KAI's extensive file of consultants and were selected because of their experience as an interviewer and professional qualifications in the social science research field. Each interviewer was given a detailed, comprehensive field training manual and other materials relating to the tasks to be accomplished. Close control over the interviewer's activities was maintained by KAI central staff to ensure that each thoroughly understood the nature of the project, the specifics of interview instruments, and the interrelationship of program to community leaders and to providers.

c. Local Program Providers

In those programs that receive Program Account 20 funds to buy some of their own T/TA services, interviews were conducted with those directly-funded providers. The names of these providers had been revealed in the course of the director telephone interview and were confirmed on-site. Then, each provider was contacted by our field representative for a telephone interview. The total number of directly-funded programs included in the sample of 30 programs is nine. (This number was larger than anticipated because Region V has converted completely to direct-funding of all programs this past year, and only one of the four programs selected for on-site interviews had not yet been a recipient of those funds at the time of our telephone interview.) Only seven of the nine programs had directly-funded providers who could be interviewed. At one program no local providers had been hired in the past year, and at the other program, non-availability of the local providers and our time limitations prevented interviews from being conducted at these two sites. At still another program with a rather large T/TA budget, only one T/TA provider who had served the program in the past year could be found.

Our total of local providers interviewed is 24. The categories and number of each type are:

Director/Manager (of organization or project)	6
Assistant Director (of organization)	1
Administration/Fiscal Services	1
Psychology/Mental Health Consultants	3
Dental Consultants	3
Medical Consultant	1
Nurse Consultants	2
Speech Pathology Consultants	2
HSST/CDA/Educational Consultant	1
Education Coordinators	2
Health Coordinator	1
Aide	1
Total	24

4. Summary of All Respondent Totals and Type of Interview

This list presents a numerical summary of all respondent categories and type of interview:

CATEGORY OF RESPONDENT	TYPE OF INTERVIEW	TOTAL
1. OCD Headquarters Personnel	In-person	24
2. National T/TA Providers	Telephone	34
3. OCD Regional Personnel	In-person	64
4. RTO/STO/STATO/OICS T/TA Provider Network (Group 1)	Telephone	42
5. Various Regional T/TA Providers (Group 2)	Telephone	77
6. Local Program Directors	Telephone	70
7. Local Program Personnel (Directors, Staff, & Parents)	In-person	428
8. Local Community Leaders	In-person	162
9. Local T/TA Providers	Telephone	24
		925

D. THE INSTRUMENTS

For each phase of the study, appropriate interview guidelines or formal instruments were designed. The primary focus of the initial interview guidelines devised for OCD Headquarters and Regional Office personnel was to elicit information which would enable KAI staff to analyze the management and delivery of T/TA at those levels. However, the primary focus of the formal interview instruments devised for Head Start local program staff, parents, community leaders, and T/TA providers was to enable KAI staff to analyze not only the management and delivery of T/TA, but also the excellence of the T/TA delivered at the grass roots level.

The instruments designed for the Headquarters and Regional Office interviews were very comprehensive and contained a number of open-ended questions. Those instruments used for local level personnel and all providers were highly structured. These instruments include the director telephone interview; the director, staff, and parent interviews (the same instrument for all with proper branching instructions); and the national, regional, and local provider interviews (the same instrument for all with proper branching instructions). All instruments were field-tested.

KAI's Technical Panel had input into the designing of instrumentation. On special request, numerous OCD personnel, e.g., CDTA staff, OCD Directors, also contributed to the task of perfecting instrumentation. All instruments for use at the local program level were approved by OMB January 23, 1975. The approval number was 085-575001 and expired June, 1975.

E. DATA ANALYSIS PLAN

The data analysis plan evolved for this project is relatively straightforward. Based on the RFP and our proposal, we had divided issues to be explored into the three major subjects - management, delivery, and excellence of T/TA - and had developed the topics to be treated under each subject. So, to analyze the data, we organized the questions from the instruments addressing each of these topics into the appropriate order.

All data from the interviews were coded and categorized by level - national, regional, and local - and by type of respondent. The primary method of analysis was simple frequencies of response on every variable, with appropriate interpretation, for each category of respondent. A bivariate analysis was also done on selected pairs of variables from the director, staff, and parent instrument to test potentially significant relationships.

Once this basic analysis was completed, the next task was to interrelate the data sources. Thus, at the national level, we had data from OCD headquarters personnel and from national providers. Not only did we have to organize the information to permit a flow from one gorup to the other, by topic, we had also, and most importantly, to interrelate the comparable data into an accurate and comprehensive piece detailing the findings. Now this same procedure occurred at the regional and local levels as well. And when all this was done, the final step was to examine the level-by-level findings and interrelate the cogent results as appropriate.

Because our approach to the presentation of data was altered during the final two months of the project, an explanation should be made to clarify the shift in format revealed in the report. Originally, part of this final report - that dealing with RO personnel responses - was submitted earlier with both frequencies and narrative comments for each topic not only on an aggregated basis across all regions, but individually by region. Because we felt it would be of value to both national and regional OCD personnel, this information has been retained as is (in both formats) for this total final report. When it came to analyzing the data from the on-site interviews, the original intent to continue this approach

item-by-item for each case study region was changed. Our sample of five case study regions had been enlarged to seven through a contract modification, thus our sample of local programs extended to 30. So a mutual decision was made by OCD contract personnel and KAI staff to aggregate the data across all regions, and highlight those variables for which individual regional variations occurred. These regional variations in data obtained from T/TA providers as well as directors, staff, parents, and community leaders associated with the local programs have not been pulled together into a single piece on each case study region. But because the variations from the "norm" have been pointed out and discussed when they exist on a variable, it is possible for the interested reader to look at a particular variable or series of variables for the information desired.

Early on in the course of the study, KAI staff had felt it was important to review some of the data from the standpoint of potential differences between directly-funded (Program Account 20 funds) and non-directly-funded programs. Therefore, we selected certain variables and proceeded to do an analysis, the results of which are presented in a special subsection at the end of Chapter III.

Now we would like briefly to discuss each instrument utilized in connection with the interviews at the local level. First, we have not included in our analysis the results of the telephone interviews conducted with 70 program directors. A synopsis of critical variables by individual program appears in Exhibit VI of this methodology chapter. The reason we did not present an analysis of these data is because these telephone interviews were used primarily as an aid for selection of our sample of 30 programs to be visited on-site. Since most of the variables in this instrument (of a total of 90) related to our selection criteria, which have been presented and discussed, an analysis of this data would have taken valuable time away from the more important pieces and added little information as well as more volume to the report.

The director, staff, and parent instruments have 249 variables, the community leader instrument, 52, and the provider instruments, 219. To the extent that it was appropriate, like questions were included on each instrument

to permit comparability of the data. In the analysis process, these similar variables were compared in each within each topical section and different or equivalent results noted. When variables unique to a particular category of respondent occur, they have been treated in the proper topical position and interrelated as appropriate.

With the director, staff, and parent instruments, a multivariate analysis utilizing 63 variables and containing 87 pairs was made. The independent variables commonly used were overall T/TA satisfaction and T/TA impact on improving the program.

With all the interviews conducted with OMB-approved instrumentation, appropriate tests of relationships and significance (e.g., Chi-square) have been made to ensure proper analysis. With all the interviews conducted with OCD, HQ and RO personnel and representatives of the RTO/STO network, important narrative responses and comments that were made by the interviewees have been carefully weighed to ensure proper analysis. This qualitative material has been integrated with the quantitative data, to provide a descriptive, analytic report based on the total body of data collected.

F. PROBLEMS ENCOUNTERED IN THE PROJECT

There were several problems encountered in the project which should be discussed. In our telephone and on-site instruments we asked the question: "Does your program receive money directly from the Regional Office to buy some of its own training and technical assistance?". Our referent in this question was Program Account 20 (T/TA) funds. We discovered that many respondents from the director group interviewed by telephone answered "Yes" but meant Head Start program, or grant, money, part of which was used for T/TA, as opposed to Program Account 20 funds. We were able to separate these two groups by calling the Regional Office PR&R Specialist for confirmation about the program's funding. All our field interviewers were alerted in the training manual and by phone about the distinction between these monies and our definition of "directly-funded programs."

Two other problems relating to the parent interviews surfaced during the on-site work. One was that a number of programs did not have parents involved in the capacities we had defined for selection: Policy (or Parent) Advisory Committee, teacher aide, or volunteer. Therefore, it was difficult in some instances to get parents who had any familiarity with T/TA. For this reason the total number of parent responses was smaller than anticipated.

The other problem with the parent interviews was that some parents, since they were not involved in very direct ways with the program activities, were not familiar with some of the language in the questionnaire. Parts of the instrument were somewhat "technical" and parents' lack of involvement prohibited knowledgeable answers. In addition, a number of the parents were not highly educated. Some of our field representatives reported that the parents felt intimidated or stupid, which was certainly not the intent, but a consequence, of the design.

A final problem involved the selection of national providers. The information we had collected from Headquarters about the amount and descriptions of each T/TA grant or contract formed the basis for our selection of national provider organizations that were included in the director (both telephone and on-site), staff, and parent instruments. From the director telephone responses, we selected as our sample of national providers ten organizations that had served the local programs in some capacity. Subsequent contacts with these provider organizations in the course of the telephone interviews revealed that our information about the T/TA delivered by the national organization was not always accurate, and because that information did not match the provider's activities, objections were raised about their inclusion in the sample.

For instance, the contractor with the largest T/TA budget, the CDA Consortium, had to be excluded from the original sample. A number of directors indicated they did receive some kind of assistance from the Consortium, but the Consortium representative we spoke with claimed they did not operate at the local level, and that they do not give any type

of training and technical assistance. We could not ascertain if the director respondents, when hearing the name "CDA Consortium" from the list of national providers, were picking up only the "CDA" portion of the name and responding in that context. We had several conversations with the CDA Consortium representative and Headquarters personnel about this entire issue of the Headquarters description of the Consortium's activities, the Consortium's explanations, and our data. A mutual decision was finally reached to drop the Consortium from the sample.

An alternate selection for the tenth provider, Transcendental Corporation was made. After many contacts, names of special consultants on that expired contract were finally submitted to us. Because of the delay imposed by the choosing of an alternate provider and their search for consultants, no interviews were conducted with this organization.

One further comment should be made about the national provider selection and responses. Some of the organizations selected were funded in Fiscal Year 1974. Therefore, respondents from these organizations were being asked about T/TA provided some time ago. The extent to which this aspect calls into question the data collected from these respondents is unknown. But the evaluation of the several processes in management, delivery, and excellence of T/TA required that we take a cross-sectional group of people at all levels, and "stop the clock," as it were, recognizing that some changes had occurred even before parts of the data collection effort began, and additionally, that some changes would occur between the time some of the data was collected and then analyzed.

This concludes our discussion of the Methodology used in this evaluation. What follows next, Chapter III, is a presentation of the data we collected and a discussion of our Findings and Conclusions.

READER'S GUIDE TO UNDERSTANDING TABLES IN CHAPTER III

Two types of tables appear in this report: simple frequencies of response by type of respondent, usually cross-tabulated by region, and bivariate data, crossing two variables by type of respondent without the regional breakdown. The presentation of each includes tables taken directly from the computer printout. For those who may not be familiar with reading tables in that format, we will briefly explain exactly how the data is presented and utilized.

Our model for the simple frequency table is the variable overall T/TA satisfaction broken out by the percentage and number of director, staff, and parent respondents in each region. Let's look at the table. In the left hand column (vertical) are listed first the variable name TTASATIS, and then the rating scale utilized for this variable, VERY SATISFIED, SATISFIED, DISSATISFIED, VERY DISSATISFIED, DON'T KNOW, and NOT APPLICABLE. (The numbers after each - 30, 31, etc., are simply our coding designations for each response.) Across the top row (horizontal) are listed first the variable name REGION and then the number of each region in our sample.

The far right hand column, labelled ROW TOTAL, presents the total number and percentage of our sample giving each particular rating across all regions, e.g., 135 persons, or 31.5% of the 428 persons interviewed (see bottom right corner), said they were "very satisfied" overall with the T/TA provided in the past year to their program. The bottom row, labelled COLUMN TOTAL, shows the total number and percentage of our sample across all ratings and answers within one region, e.g., in Region II (first column) 48 persons, or 11.2% of the 428 persons interviewed, constituted our sample there.

In the top left corner is an explanation on the figures that appear in each cell (the individual box in the crosstabulation). To be specific, the top left box presents the figures for respondents in Region II who answered "very satisfied" to the question about overall T/TA satisfaction.

FTASATIS OVERALL SATISFACT ION WITH TETA CROSSTABULATION OF BY REGION REGION

FTASATIS	COUNT / ROW PCT / COL PCT / TOT PCT	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
30. VERY SATISFIED		16	30	29	11	21	19	13	139
		11.9	21.5	21.5	8.1	15.6	14.1	7.4	31.5
		33.3	37.2	40.3	17.5	40.4	34.5	16.4	
		3.7	6.8	6.8	2.6	4.9	4.4	2.2	
31. SATISFIED		26	36	33	32	14	30	33	214
		12.1	16.8	15.4	15.0	11.2	14.0	15.4	50.0
		54.2	46.2	46.5	50.8	46.2	54.5	54.1	
		6.1	8.4	7.7	7.5	5.6	7.0	7.7	
32. DISSATISFIED		6	5	8	10	6	4	13	56
		12.5	10.4	12.5	20.8	12.5	8.0	23.2	11.7
		12.5	6.4	8.5	15.9	11.5	7.3	21.3	
		1.4	1.2	1.4	2.3	1.4	0.9	3.0	
33. VERY DISSAT		0	2	0	7	3	1	3	16
		0.0	20.0	0.0	70.0	0.0	10.0	30.0	3.3
		0.0	2.6	0.0	11.1	0.0	1.8	4.9	
		0.0	0.5	0.0	1.6	0.7	0.2	0.7	
88. DON'T KNOW		0	0	3	3	1	1	4	18
		0.0	33.3	16.7	16.7	5.6	5.6	22.2	4.2
		0.0	7.7	4.3	4.8	1.9	1.8	6.6	
		0.0	1.4	0.7	0.7	0.2	0.2	0.9	
99. NOT APPL		0	0	0	0	0	0	1	1
		0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.2
		0.0	0.0	0.0	0.0	0.0	0.0	1.6	
		0.0	0.0	0.0	0.0	0.0	0.0	0.2	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

The COUNT is 16, meaning that 16 people gave this rating. The ROW PCT is the figure immediately below 16; 11.9%, and this percentage represents the proportion of 16 respondents who answered "very satisfied" to the total 135 who were "very satisfied." These ROW PCTs add up to 100.0% across the row, since the base figure utilized is the ROW TOTAL appearing at the far right.

Below the ROW PCT is the COL PCT, 33.3%, indicating that of the 48 respondents in Region II (COLUMN TOTAL), one-third said they were "very satisfied." The last figure, 3.7%, is the TOT PCT. These 16 respondents represent 3.7% of the total sample of 428 respondents (bottom right corner). These COL PCTs add up to 100.0% down the column, since the base figure utilized is the COLUMN TOTAL appearing at the bottom of each column.

In our use of these simple frequencies tables, we have first discussed the ROW TOTAL figures, aggregated across all regions. Then, using each ROW TOTAL figure as a "norm," we have compared each region's COL PCT against the "norm" to see if a variation of 10.0% (an arbitrary figure we decided was the minimum percent acceptable to indicate variance) or more existed. Thus, looking at the COL PCT for Region II on "very satisfied," we see that it is 33.3%, which is very close to the "norm" of 31.5% of all who answered "very satisfied." Only two regions, V and XI, manifest significant variance. Both regions show a much lower percent of "very satisfied" respondents compared to the other regions. This process has been employed for all the data tables.

Turning now to the bivariate analysis, the process changes somewhat and becomes a little more difficult. The model for this bivariate discussion is the cross of overall T/TA satisfaction with effectiveness of the process utilized to assess T/TA needs and devise the T/TA plan. The region-by-region breakout does not exist because it was too complicated to incorporate in the computer programming. Therefore,

PROCEFF EFFECTIVENESS OF ASSESSMENTS BY TTASATIS OVERALL SATISFACT

PROCEFF	TTASATIS				ROW TOTAL
	COUNT / ROW PCT / COL PCT / TOT PCT	VERY SATISFIED	SATISFIED	DISSAT-VERY DIS	
		30.1	31.1	32.1	
EXCELLENT	10.	28	23	4	55
		50.9	41.8	7.3	15.3
		23.5	12.3	7.4	
		7.8	6.4	1.1	
VERY GOOD	11.	62	71	9	142
		43.7	50.0	6.3	39.4
		52.1	38.0	16.7	
		17.2	19.7	2.5	
GOOD	12.	24	79	26	129
		18.6	61.2	20.2	35.8
		20.2	42.2	48.1	
		6.7	21.9	7.2	
FAIR-POOR	13.	5	14	15	34
		14.7	41.2	44.1	9.4
		4.2	7.5	27.8	
		1.4	3.9	4.2	
COLUMN TOTAL		119	187	54	360
		33.1	51.9	15.0	100.0

across the top are the ratings scales for overall T/TA satisfaction (with Dissatisfied/Very Dissatisfied responses collasped into one because of the small number) and down the left column are rating scales for effectiveness (with Fair/Poor responses collapsed into one because of the small number). For both variables, Don't Know and Not Applicable responses have been omitted since they tell us nothing about the relationship of satisfaction to effectiveness of the process.

For the bivariate analysis, we use the ROW PCT, and can see that among those who were "very satisfied" with overall T/TA, the highest percentage rated the process effectiveness as "excellent" (50.9%). The percentage is somewhat lower for "very good" (43.7%) and then sharply declines. Among those who were "satisfied", the percentages increase from "excellent" (41.8%) to "good" (61.2%), and then declines. Among "dissatisfied/very dissatisfied" respondents, very few rated process effectiveness "excellent" and "very good"; many more said "good" and "fair/poor". The synopsis of this data can be put thusly: As satisfaction increases, the percentage rating process effectiveness at the higher levels (very good/excellent) increases. As satisfaction decreases, the percentage rating process effectiveness at the lower levels (good/fair/poor) increases. A positive relationship exists between degree of satisfaction and extent of process effectiveness.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS



MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

A. MANAGEMENT OF T/TA

The central question being addressed here is this--"Is Head Start training and technical assistance being managed effectively?" This major question has been subdivided into six topical questions to insure comprehensive plus well-integrated coverage of the questions raised in the original Request for Proposal, as well as any others that arose during the conduct of this evaluation. These six topical questions are:

M1. Are appropriate and effective Head Start objectives formulated?

M2. Is appropriate and effective policy and guidance developed?

M3. Are appropriate and effective processes followed to assess needs and devise T/TA plans accordingly?

M4. Is an appropriate and effective T/TA provider selection process in place?

M5. Are appropriate and effective quality controls exercised, e.g., reporting and monitoring?

M6. Is an appropriate and effective evaluation system being implemented?

What follows now is a discussion of KAI's findings and conclusions on each of these questions. A summation will be presented at the end of each of the six sections.

CHAPTER III

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- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION M1. Are appropriate and effective Head Start objectives formulated?

KAI staff believed the starting point for this evaluation of T/TA was "at the top" where Head Start goals and objectives are set. Goals for Project Head Start were assumed to be rather constant, i.e., those specified in the enabling legislation in the mid-1960's and reaffirmed when the program was transferred over to the Department of Health, Education, and Welfare. Objectives, however, were assumed to be ever-changing, i.e., set on an annual basis to reflect current mandates and thrusts. Hence, in the early stages of this evaluation study, an emphasis was placed on examining how Head Start objectives were set. This examination was made because the process for setting objectives were presumed to be a major indicator of the way Project Head Start is managed and, by extension, of the way training and technical assistance is managed. That is, the procedures and personnel involved in determining objectives and in implementing them are critical management concerns that impinge on T/TA budget and manpower allocations, not only in the national Office of Child Development, but also in the regional OCD offices.

In this section, the topic of the setting of Head Start objectives will be addressed from the viewpoint of OCD Headquarters officials and Regional Office (RO) staff.

a. National Level (OCD Headquarters) Responses

Project staff interviewed a total of 24 officials in OCD Headquarters in Washington, D.C. (See Chapter II for a breakdown of types and levels of officials interviewed.)

Initially Headquarters respondents were asked to describe the way in which objectives for Project Head Start get set. All of the responses received have been incorporated schematically in Exhibit VII. This summary diagram indicates the variety of factors involved in the setting of Head Start objectives. The left hand side details the factors influencing the content of Head Start objectives, ranging from consumer needs to mandates from Congress or the Executive Branch to DHEW thrusts. The right hand side lists the factors impinging on the

FACTORS INVOLVED IN SETTING OF HEAD START OBJECTIVES AT NATIONAL LEVEL

EXHIBIT VII

PROGRAM

CONSTITUENTS
- CHILD DEVELOPMENT/RESEARCH COMMUNITY
- SPECIAL INTEREST GROUPS WORKING FOR/WITH HANDICAPPED/UNDERPRIVILEGED
- CONSUMERS OF SERVICES

LEGISLATION
- ORIGINAL MISSION
- ACTIVITIES FROM OFFICE OF ECONOMIC OPPORTUNITY
- ECONOMIC OPPORTUNITY ACT
- CRIP HANDICAPS
- CHILD ABUSE LEGISLATION

EXECUTIVE BRANCH COORDINATION
- USDA SCHOOL LUNCH PROGRAM
- SPECIAL FOODS PROGRAM
- VA PUBLIC SERVICE CAREERS
- DOD USE OF RECREATION FACILITIES

DHEW COORDINATION
- SEA
- OFFICE OF EDUCATION PUBLIC SCHOOLS DEVELOPMENTAL CONTINUITY
- MEDICAID FOSTER
- PUBLIC HEALTH SERVICE
- NSA
- CREH
- ACTION
- OTHER CHD / OCD OFFICIALS

HEAD START OBJECTIVE SETTING PROCESS

MANAGEMENT

LEGISLATION
CONGRESSIONAL APPROPRIATIONS PROCESS

EXECUTIVE BRANCH COORDINATION
OFFICE OF MANAGEMENT & BUDGET - BUDGET CYCLE / MISC CYCLE

DHEW COORDINATION
- ASSISTANT SECRETARY FOR PLANNING & EVALUATION
- ASSISTANT SECRETARY COMPTROLLER
- OFFICE OF PROGRAM AUDIT / PROCUREMENT
- CONTRACTS BRANCH
- OTHER CHD, OCD OFFICIALS

process of formulating of objectives, including involvement by personnel within and without the Office of Child Development.

The respondents were requested to comment on who exactly participates in formulation of Head Start objectives. We were concerned about determining which officials within Head Start were perceived as closely involved in this objective formulation process. Not surprisingly the individuals mentioned most frequently were the Director of Head Start and his superiors. The results of this question on who participates in the setting of objectives can be seen in Table M1:

Table M1. Participants in Process of Formulating of Head Start Objectives (National Office Respondents = 24)

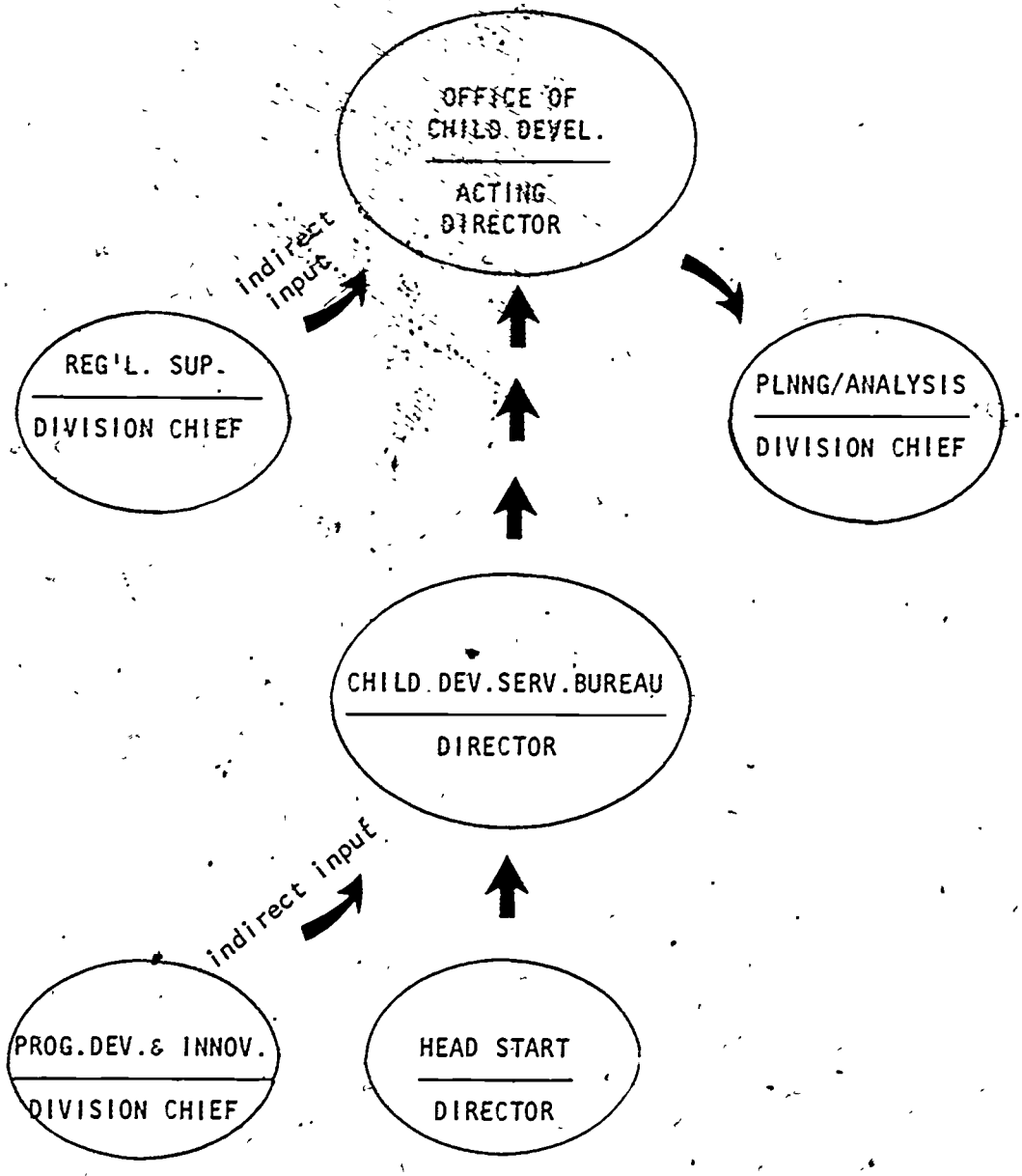
Officical	Number of Responses*
Director, Project Head Start (H.S.)	9
Director, Office of Child Development	7
Associate Director, Child Development Services Bureau (CDSB)	5
Chief, Regional Support Division (RSD)	5
Chief, Program Development and Innovation (PD&I)	4
Chief, Program Planning and Administration	1
Chief, Children's Bureau	1
Chief, Day Care Services	1
Chief, Program Management Division	1
Others	2
Total	36

*Multiple responses permitted; and not all respondents were asked this question.

This question, and the series before it, revealed a disparate set of perceptions. Table M1 shows that up to ten different individuals were names as participants in the formulation of Head Start objectives. Although directors and division chiefs tended to agree on the principal participants, the response pattern manifests a lack of consensus.

As to exactly how these various individuals integrate into the entire objective-setting process, varied comment was offered by the HQ respondents. Their discussion, subjected to the contractor's review for accuracy, have been summarized schematically in Exhibit VIII.

EXHIBIT VIII. Interaction of Participants in Process of Formulation of Head Start Objectives



Further data was requested from each HQ respondent on how the formulation of objectives process at the national level meshes with similar processes at both the regional and local levels. What emerged, despite once more widely varying answers, was a series of events that can fairly well be sequentially delineated. The President's annual proposed budget submission to Congress serves as a catalyst for the DHEW-wide MBO cycle. In OCD, each major division submits proposed objectives to the Director, who in turn reviews them and, if they win approval, passes them on to the Division for Planning and Analysis.

Regional office input was described as occurring through a variety of channels including the on-going and informal dialogue necessary to program operations, staff meetings ("retreats" at Warrenton and Williamsburg, Virginia specifically were mentioned), and Task Forces related to special issues. Several persons remarked that the regional offices are asked at the appropriate time to react to draft national objectives.

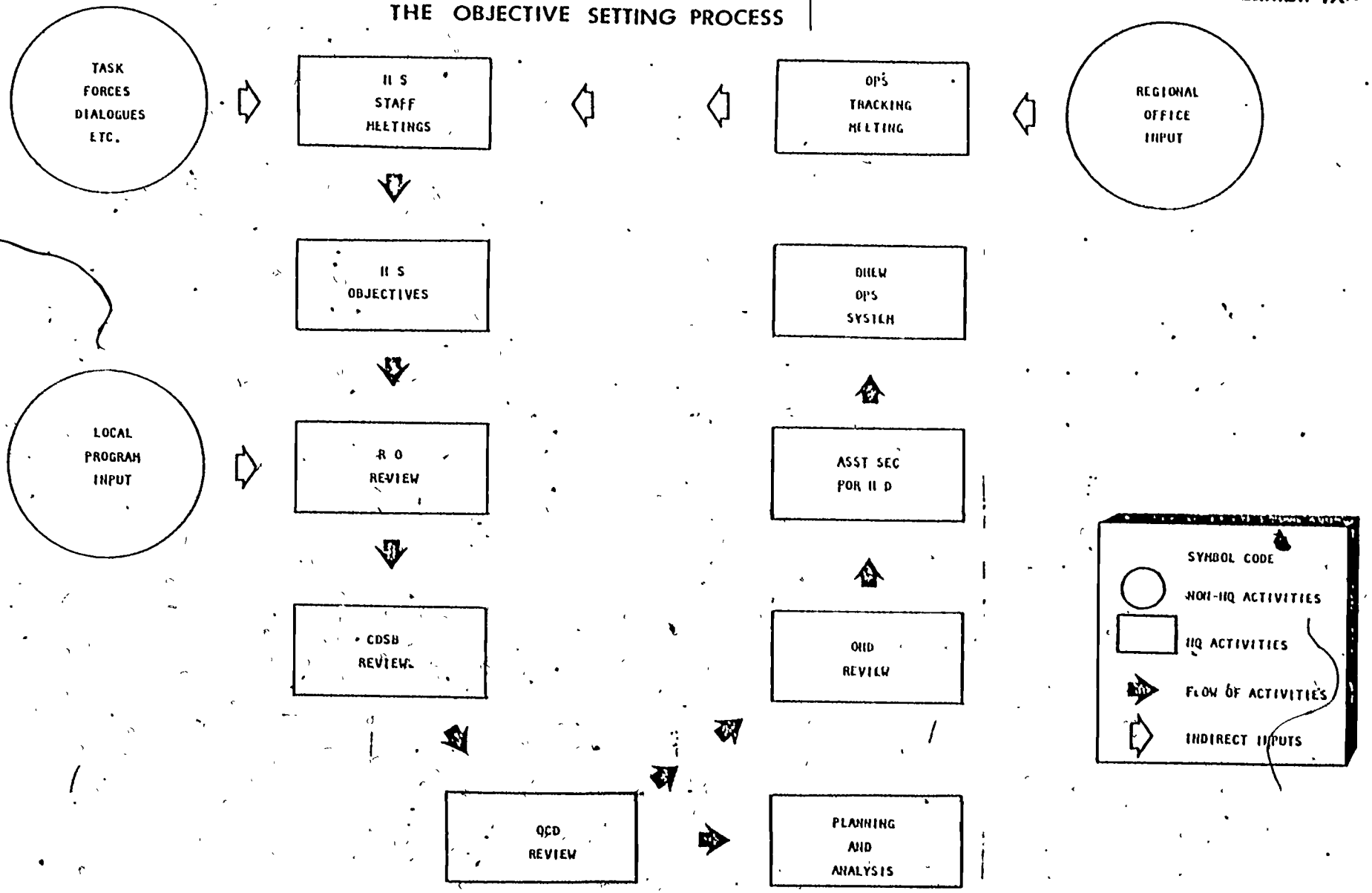
Local level input was described as occurring indirectly, i.e., through the regional offices. The perceived implications of this indirect input varied, as evidenced by these types of comments:

- local impact is not much since demise of national conferences;
- local input is filtered through the Regional Offices;
- Regional Offices may be asked to get local input.

This entire three-level process (national, regional, and local) has been described schematically in Exhibit IX. The squares represent the sequence of events--based on the information given to us--and the circles represent previous, ongoing, or implicit flows of information. For example, the initial discussion of Head Start objectives occurs in an environment in which contact with Regional Offices has occurred through Task Forces, on-going dialogues, etc., so that Regional Office input may be informally or implicitly included even at the initial stages.

Exhibit IX.

THE OBJECTIVE SETTING PROCESS



The respondents were asked to comment on the priority given by the National Office to regional level input into the formulation of Head Start objectives. The answers varied but included these comments:

- "top"
- pretty high
- depends on how relevant and valid input is
- rather heavy
- no priority
- "lip service"

The significance of the local level input was harder to come by. Those comments which were made tended to either describe local input as incorporated or represented by Regional Office input or to indicate that local input was of less priority.

Headquarters respondents were asked about possible improvements in the process for setting Head Start objectives. Answers given are displayed in this table:

Table M2. Improvements in Process of Formulating Head Start Objectives (National Office Respondents = 24)

Improvements	Number of Responses*
More Regional Office Input	7
More local input	5
Better timing	2
Better feedback	1
National conferences	1
	16

*Multiple responses permitted; not all respondents were asked this question.

Clearly, most respondents on this subject were concerned with increasing Regional Office and local inputs into the process of setting national objectives.

Headquarters respondents were shown a list of the FY 74 Head Start Objectives and asked to give their opinion and how successfully they had been achieved. The results are displayed in Table M3:

Table M3. Success in Achieving FY 74 Objectives (National Office Responses = 24)

FY 74 Head Start Objectives	Categories and Frequences of Responses					
	Excellent	Very Good	Good	Fair	Poor	NA
Performance Standards by 6-30-74	1	3	2	4	2	
Needs Assessment System (local) by 6-30-74			1	6	3	
T/TA Needs Assessment		2	2	4	3	
Cost Management Guidelines by Fourth Quarter FY 74			1		4	2
Process for review and support of OCD RO of Head Start objective policies				2	5	
10% of enrollment opportunities for handicapped	2	4	7			
Screening and diagnostic tools by 6-30-74		2		2	3	2
TOTAL	3	11	13	18	20	4

In appraising Head Start's success in achieving its national objectives, the most frequent category of response at the Headquarters level was that achievement had been "Poor" or "Fair." The only exceptions to this general appraisal were objective one on implementing the performance standards (in which 50% of the responses were "Good" or higher) and objective six on providing 10% enrollment for handicapped (in which all responses were "Good" or "Very Good" or "Excellent.")

A variety of problems were cited by HQ respondents as interferring with the attainment of National Head Start objectives. Staff shortages (five responses) and insufficient funds (three responses) were the most frequently cited responses, but aside from "low morale" cited by two persons, each respondent had a virtually unique diagnosis. In general, however, all other comments fell into two categories: (1) organizational dissatisfaction comments, reported variously as poor communications, fragmentation among staff, need for more staff meetings, Regional Office confusion about goals and objectives, lack of leadership in some HQ divisions, conflict in functional and administrative responsibilities at the Regional Office level, etc.; and (2) management processes or systems comments, reported variously as lack of a management information system, tardiness in reviewing Regional Office plans, need for earlier initiation of planning process, etc. It is hard to even separate responses into these categories because the diversity and lack of consensus makes the process of categorizing very judgmental and arbitrary.

b. Regional Level (Eleven Regional Offices) Responses

Project staff interviewed 64 officials in regional offices. (See Chapter II for a breakdown of types and levels of officials interviewed.)

Regarding the processes followed by OCD Headquarters in formulating objectives, officials tended to report -- much like the national officials -- divergent opinions on how much input they had in the devising of the objectives.

On the subject of possible improvements in the process, these regional respondents also tended to mention most frequently the need for a better system for regional input and for local program input into the process. This pattern matches that which became obvious from the OCD Headquarters responses.

Finally, as happened with the Washington, D.C., OCD officials, all of these regional office staff were shown a list of the FY 74 Head Start Objectives and asked to give their opinions on how successfully they had been achieved. The results are given in Table M4:

Table M4. Success in Achieving FY 74 Objectives (Regional Office Responses = 64)

FY 74 Head Start Objectives	Categories and Frequencies of Responses					
	Excellent	Very Good	Good	Fair	Poor	NA
Performance Standards by 6-30-74	4	7	8	7	2	
Needs Assessment System (local) by 6-30-74	3	2	8	7	1	
T/TA Needs Assessment	3	3	6	5		
Cost Management Guidelines by Fourth Quarter FY 74		1	5	6		
Process for review and support of OCD RO of Head Start objective policies	1	2	3	1	7	
10% of enrollment opportunities for handicapped	4	4	6	4		
Screening and diagnostic tools by 6-30-74	2	2		7	6	
TOTAL	17	21	36	36	16	

Generally, the regional respondents tended to note the success Head Start had in achieving its FY 74 national objectives more positively than national OCD respondents. Specifically, they also gave the highest marks to the objectives regarding the performance standards and opportunities for the handicapped.

Summation of M1 Findngs: Head Start Objectives

The question about which information was sought was "are appropriate and effective Head Start objectives formulated?"

A key finding that emerged at the national level is that a multiplicity of factors affect both the process and the content for formulation of objectives (see Exhibit VII). Among the factors cited were consumer needs, legislative mandates, Executive Branch thrusts, and DHEW concerns. Within OCD HQ a lack of consensus existed regarding exactly which officials were involved in the reacting to these factors and setting up the objectives. Those officials perceived to be most closely involved in the decision-making process were the Director of Project Head Start, the (Acting) Director of OCD, the Associate Director of the Child Development Services Bureau, the Chief of the Regional Support Division, and the Chief of Program Development and Innovation (see Table M1). But staff at the National Office appeared not to understand consistently who the "key players" were when it came to setting up objectives, nor were they as clear regarding the exact process that was followed in the formulation of objectives.

At the regional level the basic finding was that regional input into the national process for formulation of objectives varied greatly and that local input into the process, when it occurred, usually was through the channel of a particular regional office. A number of respondents at both the national and regional levels reported that the objective-formulation process could be improved with more regional officer and local program input. This phenomenon tends to support the other finding from those interviewed that the current overall level of input from regional and local sources is less than substantive.

Both national and regional interviewees were asked to rate how successfully they thought Head Start had achieved its FY 1974 objectives (see Tables M3 and M4). Generally more OCD HQ respondents gave lower ratings than did RO respondents. On each point of the rating scale across all the objectives, the

percentages of national responses compare to those of regional responses as follows:

	National	Regional
Excellent	12.5%	26.5%
Very Good	45.8%	32.8%
Good	54.2%	56.2%
Fair	75.0%	56.2%
Poor	83.3%	25.0%

The percentage of national office respondents increases as the rating measure declines on the scale. With the regional office respondents, a similar pattern is evident until the lowest rating, poor, is reached, at which point the percentage decreases dramatically. National office respondents indicated most often that staff shortages and insufficient funds prevent the attainment of greater success in achieving Head Start objectives.

To two objectives receiving the greatest proportion of high ratings (excellent and very good) from both groups were performance standards and 10% enrollment for handicapped children, although for the latter objective, a higher percentage of national than regional staff felt success was high.

These findings on the FY 1974 objectives suggest several things. One, there was an enormous amount of ignorance exhibited by both national and regional respondents on the meaning of some of the objectives (most notably, "cost management guidelines" and "process for review and support of OCD RD of Head Start objective policies"). Two, those objectives which have the force of policy behind them (e.g., performance standards, 10% enrollment for handicapped) receive the greatest attention and effort at implementation; those which do not have such authority behind them achieve either a modicum of or very little success. Three, those objectives for which regional offices have primary responsibility in implementation (again, for example, the performance standards and 10% enrollment opportunities for handicapped) tend

to be rated more highly successful by both national and regional respondents than do objectives for which the national office has primary responsibility.

Overall, one major problem area emerges from these data on objectives. That problem involves organizational communication issues, both within the national office and between the national and regional offices. At OCD HQ, knowledge of the process used for objective formulation tends to be diffuse, vague, and sometimes inaccurate. Staff members throughout the Head Start Division (CDTA, PMD, IMPD), as well as in other OCD divisions related to the T/TA program (RSD, PD&I, etc.), indicated either conflicting information on how national objectives were formulated, or were totally unaware of how they were formulated. This formulation process is also now part of the wider process of setting objectives for the Office of Human Development. This system apparently has not been clearly defined so that all OCD staff, especially those who are involved in T/TA activities, are aware of it. This situation has ramifications in the Regions as well. Regional staff interviewed generally were unaware of the process followed in OCD HQ for objective formulation. The end result is that input from concerned staff at either the national or regional levels into the formulation of national Head Start objectives is not facilitated. Ultimately, this will hamper Project Head Start in formulating the most appropriate national objectives. Further it will make it more difficult for Head Start to achieve its objectives, since the process for formulating them was not as inclusive of various national and regional officials as it might have been. The more people at both levels who understand the formulation process and have an opportunity to participate in it, the more who consequently will have a stake in the objectives that result and who therefore will be more highly motivated to implement them.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
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- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION M2. Is appropriate and effective policy and guidance developed?

Just as it seemed important to examine the process followed to formulate Head Start objectives, so too it seemed essential to investigate the way in which Head Start policy and guidance is devised. As with the objective formulation process, KAI staff presumed that the development of appropriate and effective policy and guidance is a major indicator of the way in which Project Head Start is managed and, by way of extension, of the way training and technical assistance is managed.

In this section, the topic of development of policy and guidance will be discussed from the viewpoint of OCD Headquarters and regional office officials.

a. National Level (OCD Headquarters) Responses

Project staff asked each of the respondents at OCD Headquarters to define policy and guidance. There was considerable consensus among all interviewees that the weight of authority distinguishes the two: policy is authoritative or directive and guidance is efective and optional. For example, definitions offered for "policy" included:

- mandatory
- regulations, requirements, rules
- objectives to be achieved
- procedures, conditions, requirements
- "must do"

And definitions offered for "guidance" included:

- discretionary
- "how to"
- methods to comply with policy
- helps people implement (policy)
- about policy
- "take it or leave it"

The process by which policy and/or guidance is developed generally involves first, a determination of what needs to be done in terms of program matters, and second, the actual drafting of the appropriate issuance. The Head Start director and division chiefs usually bear the responsibility of formulating what is required, and frequently delegate the drafting to a staff specialist. Regional Office personnel and/or particular contractors may be consulted at times throughout this process.

Several staff members indicated that, within their particular division, there was little opportunity for input into the development of policy or guidance. Since these individuals had some contact with Regional offices and familiarity with concerns at the local level, they felt they could make a valuable contribution to the process but did not have an opportunity to do so.

As to types of policy and/or guidance which need clarifying, some respondents mentioned that the definition of compliance with the performance standards is not well-conceived or uniformly known. Therefore, much variation occurs among the regions in what constitutes compliance. Another area needing attention is the Head Start manual. Several Headquarters respondents made references to the soon-to-be-completed revised Head Start Manual but no one knew exactly when the finished product would be available.

Next this group of respondents was requested to describe the process used by Headquarters to disseminate policy and/or guidance after it was devised. There was general agreement in the answers given that the process employed for dissemination appears to be related to the nature of the content involved. Important communications dealing with major issues or significant changes may require extensive explanations and the interactions of a conference or workshop, while

other less weighty matters can be handled in standardized written instructions or memos, and still others may require only a telephone call or verbal exchange.

Finally, on this subject, the Headquarters interviewees were queried on what processes are in place to get feedback regarding policy and guidance after it has been distributed from the National Office. Among the responses received were:

- a monthly reporting system from Regional Offices which handles certain types of information
- on-site inspections by Headquarters personnel
- telephone confirmations

In short, answers to this question varied, but collectively indicate that the respondents understood the numerous possible feedback mechanisms that might be appropriate in various circumstances.

b. Regional Level (11 Regional Offices) Responses

In most regions policy is developed, but it tends to be operational policy within the particular region. Guidance for both providers and programs is developed in most regions also. The content of this guidance relates to budget, administration, planning, needs assessment, and miscellany (staff salaries, transportation/safety, parent committee involvement, etc.).

As to the process by which policy and/or guidance is formulated, the issue usually arises from questions or problems from the field. Regional office staff then discuss solutions among themselves, and may consult with Headquarters and local program directors and staff about the draft. Those people on the regional staff most frequently involved are the OCD Director, PR&R Specialist (or the equivalent), Community

Representatives, ad hoc groups, and occasionally, the Assistant Regional Director.

In terms of policy and/or guidance needs, respondents mostly frequently mentioned the following items. The T/TA planning guidance that changes yearly should be revised to permit an early, and knowledgeable accommodation to consistent national office requirements. In the past, each year has brought not only new content but new format which has placed excessive burdens on regional office staff. The time frame within which the regional office T/TA plans have had to be formulated has been short. And the basis for acceptance of each region's plan has not been understood.

Performance standards compliance was another issue frequently mentioned. Of particular concern was a definition of what is meant by compliance with the standards.

Other areas needing up-dating included policy on renovation, suspension/termination of grantees, seasonal work issues, and nepotism.

Regional office staff were then requested to specify how objectives, policy, and guidance were disseminated from the national office to the regional office; and from the regional office to the local program. The most common approach was mailing of draft materials with follow-up memorandums. Most mailings to each grantee detailing specifics were mentioned by several respondents as the means of getting the information on the local level. Feedback from the local programs about a particular issuance comes through phone calls, letters, provider meetings, and visits by the Community Representatives.

Summation of M2 Findings: Policy and Guidance

The question addressed was whether or not appropriate and effective Head Start policy and guidance is being developed. As mentioned at the beginning of this section, it is a topic which transcends but also directly effects T/TA.

Changes in the past months have lessened some of the problems expressed as to appropriate and effective policy-guidance development. The publication of the performance standards in the Federal Register makes them have the force of policy and clarifies that major issue in terms of implementation. Definition of compliance remains nebulous however and should be clarified.

New procedures in regard to the yearly regional T/TA plans, initiated for Fy 1972, may reduce or eliminate the problems of yearly changes in content, level of specificity and format of information, inadequate amount of time in which to develop the plan, and unclear predetermined basis for acceptance of each region's plan expressed by regional respondents. The current reorganization of national OCD divisions and responsibilities will impact not only on this issue but on other policy and guidance issues as well, so it is not possible at this time to forecast with any certainty whether the changes incorporated in the FY 1976 T/TA regional planning procedures will be maintained, refined, or altered again.

Up-dating of the Head Start Manual is, according to many national respondents, in process. When this process is completed, and if the changes incorporated reflect present realities and resolve current issues, a number of policy and guidance problems surfacing at the local and regional levels will be reduced.

In short, several steps implemented during the past year by the national OCD staff have brought Head Start policy and guidance much closer to being both appropriate and effective.

Implicit in this discussion on policy and guidance, as well as in that on objectives, is the larger issue of a system imposing its will from the top down. Through direct requirement (e.g., T/TA planning guidance and performance standards policy) the national office compels not only the regional offices but local programs also to go through complicated and time-consuming activities without proper guidelines to promote high effectiveness. Through indirect requirement (e.g., out-dated Head Start Manual and lack of assessment tools), the national office forces the regional offices and local programs to operate in areas where voids exist or to generate their own guidelines to fill the gaps. Now, while the latter encourages regional office autonomy and many in fact increase responsiveness to local needs in some areas, overall it appears to hamper the conduct of the Head Start program because valuable time and energy is spent searching for ways to fulfill requirements not thoroughly prepared for or clearly defined. Bearing directly on this issue also is the fact that local level input into the formulation of policy, guidance, and objectives filters up from the regional offices to the national. It is unevenly incorporated into regional offices, and appears to be minimally incorporated at the national office level. Some regional office respondents spoke of the lack of national office awareness about how much effort local programs have to expend "just to keep the doors open". It appears that this entire issue of nationally-imposed requirements, some of which critically affect T/TA activities at the regional and local levels, warrants closer scrutiny to effect solutions that promote heightened effectivess of operation at all levels.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION M3. Are appropriate and effective processes followed to assess needs and devise T/TA plans accordingly?

This is the first of these topical questions that relates directly to training and technical assistance. It is assumed that, by definition, T/TA is intended to supplement or fill the gaps in what a given local Head Start program has available as resources to achieve objectives and to serve its child and families. Consequently, it follows logically that some sort of effort must be expended in order to ascertain the strengths and weaknesses are in need of overcoming through T/TA. This is what is meant by "assessing needs and planning for T/TA accordingly." This activity is presumed to be a major indicator of the way in which Head Start T/TA is managed.

In this section, the topic of assessing needs and planning for T/TA accordingly will be discussed at the national, regional, and local levels.

a. National Level Responses

National level responses on this topic of needs assessment and planning, and all other succeeding topics in this chapter on findings are discussed first from the viewpoint of OCD Headquarter officials and then from that of national T/TA providers.

1. OCD Headquarters Responses

Initially, inquiry was made of the 24 National Office respondents as to needs assessment activities at local, regional, and national levels. The information gathered from National Office Head Start staff strongly indicates that the central offices has little or no direct responsibilities or duties in any needs assessment process. Some central office personnel see their responsibilities limited to the construction of relevant needs assessment data gathering forms, and to centrally tabulate data as it is gathered from the local and regional levels.

The central staff perceived few needs assessment duties for themselves because core needs assessment data must be generated primarily at the local level. Thus, the function of the local level is to initiate and conduct all relevant field needs assessment procedures, and subsequently forward such data to the Regional and National Offices for tabulation, analysis, and establishment of future objectives.

Central office staff regarded the Regional Offices' responsibilities to be focused on a "quality control" function to insure comprehensive and accurate needs assessment procedures at the local level. It was recognized that this quality control function is necessary to insure uniformly beneficial local needs assessment data for use by the Regional Offices.

Of the ten OCD headquarters staff who gave specific responses to questioning relative to the T/TA needs assessment activities the answers were distributed as follows:

Table M5. Headquarters Role in T/TA Needs Assessment (National Office Respondents = 10)

Responses	Frequency
National Office has little or no T/TA needs assessment tasks	10
Local programs have primary T/TA needs assessment responsibility	10
Regional Office must maintain a monitoring system of local program T/TA needs assessment activities	4
Not enough time available for more Regional Office involvement	3
National Office might design T/TA needs assessment format(s) and tabulate national needs, etc.	2

(some respondents gave multiple answers.)

Next, OCD headquarters personnel who were interviewed were requested to describe the planning process that is followed at the three levels (national, regional, and local) to incorporate the results of needs assessments into program planning processes.

Several respondents in the central office said that they perceived relatively little attention paid to the needs assessment process in the setting of objectives or the devising of program policies. It was recognized that the National (and to some extent the Regional) Office held the responsibility to set national Head Start objectives and to engage in activities supportive to the achievement of objectives through sound policy development. However, the survey did not reveal any established and concerted planning processes internal to headquarters (or regional offices) which would ensure that subsequent objective setting and policy development would indeed be firmly rooted in a comprehensive needs assessment. Many respondents were emphatic to the point of saying that no such internal planning processes occurred at either the national or regional levels.

One significant problem noted in this regard is the disparity between the Program Year End(s) and the Fiscal Year End. The different operational time frames for large numbers of the local level programs and the activities of the Regional and National Offices complicate the completion of needs assessment and planning processes in a timely fashion.

OCD headquarters officials interviewed were asked to rank the effectiveness of both the needs assessments and total planning processes at each level (national, regional, local) of Head Start.

On a scale of Excellent/Very Good/Good/Fair/Poor, the interviewees showed a marked tendency to rate the processes at the three levels (national, regional, and local) in the same scale category, i.e., if a respondent perceived the national level of effectiveness to be "Fair", there was high probability that he/she felt the regional and local levels to be "Fair" also. The overall response pattern reveals a skewing of the distribution of the data at the "low" end

of the scale, with the central tendency measures of the mean, median, and modal points all falling within the "Fair" category.

As would be expected from the above dicussion, the central office staff regarded the overall quality and impact of the needs assessment and planning process to be an area in which substantial improvement might be made.

2. National T/TA Providers Responses

Project staff interviewed a total of 34 national providers of T/TA. (See Chapter II for a breakdown of these and other T/TA providers interviewed.)

Initially, as was the case with the OCD Headquarters officials, the national T/TA providers were asked whether or not they were involved in the T/TA needs assessment and planning activities at the national, regional, state, and local levels. National providers responding "Yes" to this series of questions are detailed as follows:

Involved at national level	50.0%
Involved at regional level	41.2%
Involved at state level	17.6%
Involved at local level	29.4%

With the exception of "involved at the local level," the figures show a declining proportion of national provider involvement in T/TA needs assessment and planning as the level gets more removed from national. Involvement does rise again when the local level is reached. This increase can be explained by the fact that the health, handicapped, and specific grantee (e.g., PCC, JMPD) consultants work with the local programs in the assessment and planning activities related to their particular component.

This data tends to indicate that the national T/TA providers are more involved in needs assessment and T/TA planning activities at the regional, state, and local levels than are the OCD headquarters officials. Among other things, this is probably attributable

to the fact that the national office role is more policy-oriented than that of the providers which is more concrete and concerned with the implementation of policy via such activities as needs assessment, etc.

The national providers were asked to indicate what criteria from the following listing they utilized to determine their activities as a provider. The percentage of "Yes" responses and rank order for each criterion are given in Table M6:

Table M6. Criteria Utilized to Determine Activities of National Providers

Criteria Utilized to Determine Provider Activities	Percent of National Providers (n=34)
National Head Start Objectives	85.3
Regional Head Start Objectives	73.5
Local Head Start Objectives	70.6
Performance Standards	91.2
Community Needs	73.5
Staff Needs	88.2
Volunteer Needs	50.0
Parent Needs	79.4
Amount of Money Available	70.6
T/TA Plan	58.8
Part of Grants Application	47.1
Contract Requirements	52.9
Other Contracts	23.5
Other	8.8

The three most frequently-mentioned criteria were performance standards (91.2%), staff needs (88.2%), and national Head Start objectives (85.3%). Thus, two out of the three top criteria for determining national providers' activities generate from the national office.

National provider respondents were asked to name the top three criteria, in order of importance, used to determine their T/TA activities. Table M7 shows the percentage of respondents ranking criteria in order of first, second, and third importance.

Table M7. Top-Ranked Criteria for Determining T/TA Activities of National Providers (n=34)

Criteria Named for Determining T/TA Activities	Percent of National Providers' Response			
	First-Ranked	Second-Ranked	Third-Ranked	Aggregate
National Head Start Objectives	26.5%/1	17.6%/1	5.9%/4	50.0%/1
Regional Head Start Objectives	8.8%/4	11.8%/3	8.8%/3	29.4%/3
Local Head Start Objectives	11.8%/3	2.9%/5	2.9%/5	17.6%/6
Performance Standards	14.7%/2	14.7%/2	11.8%/2	41.2%/2
Community Needs	---	2.9%/5	---	2.9%/12
Staff Needs	11.8%/3	2.9%/5	8.8%/3	23.5%/4
Volunteer Needs	---	2.9%/5	---	2.9%/12
Parent Needs	2.9%/6	8.8%/4	---	11.7%/8
Children Needs	---	2.9%/5	---	2.9%/11
Amount of Money Available	---	2.9%/5	17.6%/1	20.5%/5
T/TA Plan	---	8.8%/4	2.9%/5	11.7%/8
Part of Grants Application	---	---	8.8%/3	8.8%/9
Contract Requirements	5.9%/5	---	5.9%/4	11.8%/7
Program Needs Assessment & Evaluation	2.9%/6	2.9%/5	---	5.8%/11
Provider Self-Assessment & Evaluation	---	---	2.9%/5	2.9%/5
Other	2.9%/6	2.9%/5	2.9%/5	8.7%/10
No Response or Not Applicable	11.8%	14.7%	20.6%	---

Among the first-ranked criteria, national Head Start objectives (26.5%), performance standards (14.7%), and local Head Start objectives and staff needs (both 11.8%) were top-ranked. Among the second-ranked criteria, national Head Start objectives (17.6%), performance standards (14.7%), and regional Head Start objectives (11.8%) were top ranked. Among the third-ranked criteria, amount of money available (17.6%), performance standards (11.8%), and regional Head Start objectives, staff needs, and part of grants application (all 8.8%) were top-ranked. Aggregating the "Yes" responses given across each criterion shows that the top three criteria utilized by national providers interviewed to determine their T/TA activities were national Head Start objectives, performance standards, and regional Head Start objectives.

It can be seen that when these providers ranked the criteria, the order did not change dramatically from the rank order of responses given when they were asked to indicate whether or not they used each criterion listed (Table M6). Although some variations appeared when respondents were asked to rank importance of criteria most of these variations occurred outside of the top three most-frequently mentioned in both questions.

National providers were also asked to specify which of the following types of resources they use to assess T/TA needs and devise the T/TA plan. The frequency for each type is presented below in Table M8.

Table M8. Resources Utilized by National Providers for Assessing T/TA Needs and Devising T/TA Plan (n=34)

Type of Resource	Percent of National Providers Utilizing Resources
Formal needs assessment tools	55.9
Program Staff evaluation forms	29.4
Program Staff meeting	41.2
Provider reports (RTO/STO/STATO/OICS)	41.2
Other providers reports	11.8
Staff evaluation forms	32.4
Staff meetings	38.2
National Office materials/guidance	67.6
National Office staff (e.g., COTA, PD&I, etc.)	50.0
Regional Office materials/guidance	47.1
Regional Office staff (e.g., Community Representative)	61.8
Other	17.6
Not Applicable	11.8

National Office materials and guidance were mentioned by most respondents (67.6%), followed by Regional Office staff, e.g., the Community Representative (61.8%), formal needs assessment tools (55.9%), and National Office staff, e.g., Career Development and Technical Assistance division, Program Development and Innovation, etc. (50.0%). All other responses fall below the 50.0% mark, of course, variations in the contractual requirements and in Regional Office utilization of specific national provider consultants account in part for the data distribution.

These respondents were then asked if they prepare a written T/TA plan or work statement for their activities. The frequencies of response were:

Yes	64.7%
No	23.5%
Not Applicable	11.8%

About two-thirds of the national providers interviewed did prepare a written plan or work statement. (The "Not applicable" responses are either from ERIC personnel or another provider whose contract had expired.)

Those people who answered "Yes" were then asked to specify to whom and how often the written plan or work statement was submitted. Their responses are displayed in Table M9 below:

Table M9. Percent of National Providers Submitting Written T/TA Work Plan to Organization or Agency and Frequency of Submission (n=34)

Recipient of Written T/TA Plan	Percent of National Providers Submitting Plan	Frequency of Submission				
		Monthly	Quarterly	Semi-Annually	Annually	Other
Employer	29.4	11.8	2.9	--	8.8	5.9
Policy Advisory Board	2.9	--	--	--	--	2.9
Grantee Board	5.9	--	--	--	--	5.9
State T/TA Grantee	2.9	2.9	--	--	--	--
Regional Office	29.4	5.9	2.9	--	11.8	8.8
National Office	35.3	--	8.8	2.9	17.6	5.9
Part of Grants Application	5.9	--	--	--	2.9	2.9
Part of Contract Requirements	11.8	--	--	--	--	11.8

(Note: Because this question was designed to permit multiple responses for the recipient part only, no item totals 64.7%, the number of respondents answering "Yes" to the preceding question, which asked if they prepare a written T/TA plan or work statement for their activities. The percentages in the frequency colums are based on the total number of respondents, and in every instance total the percent listed in the second column.) Respondents were allowed to give only one frequency, that which represented the shortest interval.

This table reveals that a low number of national providers were required to submit written T/TA plans or work statements to any organization or agency. The most common recipients of such plans were the National Office (35.3%), the individual's employer (29.4%), the Regional Office (29.4%), and other (11.8%). "Other" included such responses as the "National Institutes of Education," "other staff members in the provider organization," or that the plan was simply made up by the individual for himself. The low number reporting that plans were submitted to the National Office can be accounted for in part by these qualifications: the responses in "part of grants application" and "part of contract requirements" do not reveal the possibility that those stipulations included reporting to the National Office; and, a few respondents knew that they submitted a written T/TA plan but were not sure who finally got it. However, even allowing for these respondents who might have specified "National Office," the total percent at maximum could have been no more than 64.7%, the same number who said they did prepare a written T/TA plan or work statement.

Regarding frequency of T/TA plan or work statement submission, the table show that, most often, employers received monthly T/TA plans (11.8%), the Regional Office annual plans (11.8%), and the National Office annual plans (17.6%). Under the frequency labeled "Others," responses included "as necessary," "after each site visit," "before a workshop," and "at end of contract."

Overall, while the majority of respondents did write a work plan, the recipients and frequency of submission were varied.

Then, as with the OCD headquarters officials, the question was asked, "how effective is the process you use to assess the T/TA needs and devise your T/TA plan?" They were given five possible answers: "excellent, very good, good, fair, or poor."

Table M10. Effectiveness of T/TA Needs Assessment and Planning Process (National Providers. n=34)

Response	Percent of Providers
Excellent	20.6
Very Good	32.4
Good	26.5
Fair	11.8
Poor	--
Not Applicable	8.8

Nearly 80% gave responses on the positive side of the scale (excellent, very good, good). No one rated the processes as "poor."

This data represents a dramatically different perception on this subject from that of the OCD headquarters officials who were interviewed and who tended to rate these processes at or near the "fair" part of the scale.

Next, these national providers were queried as to how much improvement they thought was necessary in these processes. On this subject of improvement needed, the responses were:

Table M11. Extent of Improvement in National Providers' T/TA Needs Assessment and Planning Processes (n=34)

Response	Percent
A Great Deal	5.9
Quite a Bit	11.8
Some	47.1
A Little	14.7
None	8.8
Not Applicable or No Response	11.7

Those who perceived rather extensive improvements (a great deal/ quite a bit) needed fell below 20% of the total number of respondents; those who indicated little or none totalled 23.5%, those who the relatively middle position of "Some" totalled nearly half the respondents.

This finding also differs considerably from that uncovered when interviewing OCD headquarters officials. They rated the processes lower than the national providers and tended to report that a lot more improvement was needed than did the providers. Perhaps this difference in perception can also be explained theoretically in that the providers would be more directly-involved and hence have more accurate perceptions. However, it is also true that they have more to gain than OCD officials by reporting on such T/TA activity in the best possible light.

After having discussed their perception on various aspects of needs assessment and T/TA planning processes, these national providers were asked to rate the effectiveness of the coordination, in terms of planning for T/TA at the local level, between their organization and each of the these offices: the National Office; the Regional Office; the State Training Office (or its equivalent); and the local grantee. In order to offer a rating for any one of these groups, each respondent had to be involved in the needs assessment process for T/TA at that particular level, and this information was known because of a previous question asked. The answers from that previous question are presented again here for convenience.

Level of Involvement by National Providers in T/TA Needs Assessment and Planning Process	Percent of National Providers Involved
National Level	50.0%
Regional Level	41.2%
State Level	17.6%
Local Level	29.4%

With these respondents who were involved in the T/TA needs assessment and planning at any one of these levels, the appropriate rating question was then asked.

Before launching the discussion of these data, another point must be made. The exact wording of this series of questions was: "How would you rate the effectiveness of the coordination between the (appropriate office name appears here -- National Office, Regional Office, State Training Office, or Local Grantee) and your organization in terms of planning for training and technical assistance at the local level? Would you say it is excellent, very good, good, fair, or poor?" This question was deliberately worded "in terms of planning for training and technical assistance at the local level" (emphasis on local added here) because of our belief that most planning for T/TA ultimately must affect local level Head Start programs, no matter where that T/TA planning originates. (Note: The number of respondents giving ratings on the coordination effectiveness of the National Office, the State Training Office, and Local Grantee is one less than the number of respondents who indicated they were involved in T/TA needs assessment and planning at each of those three levels. In each of those instance, the respondent answered "Not Applicable" for the coordination effectiveness ratings.)

Table M12 shows the percentage of responses rating coordination effectiveness with each office or agency. Of the 50.0% of national providers who indicated involvement at the national level, 44.1% offered a rating (excluding Don't Know and Not Applicable). Most respondents who gave a rating reported the effectiveness of coordination between their organization and the National Office "Very Good" (46.7%). In fact. the positive responses -- excellent, very good, and good --

totaled 80.0% of all ratings given. No one rated coordination effectiveness with the National Office "Fair," but 20.0% did give the rating "Poor."

Table M12. National Providers' Rating of Effectiveness of Coordination in T/TA Planning at the Local Level Between Their Organization and the National Office, Regional Office, State Training Office, and Local Grantee

Rating	Percent of National Providers Rating Effectiveness of Coordination With Each Office			
	National Office	Regional Office	State Training Office	Local Grantee
Excellent	6.6%	7.1%	20.0%	22.2%
Very Good	46.7%	28.6%	--	--
Good	26.7%	35.7%	20.0%	33.3%
Fair	--	21.4%	20.0%	44.4%
Poor	20.0%	7.1%	40.0%	--
n =	15/34	14/34	5/34*	9/34*
Not Reported	39	20	29	25

*Substantially fewer respondents replied in these categories.

All of the 41.2% of national providers who indicated involvement in the T/TA needs assessment and planning process at the regional level rated the coordination effectiveness between their organization and the Regional Office. One-third of these respondents said "Good" (35.7%). Totaling the group of positive responses (excellent, very good, good) results in a figure of 71.4%, slightly lower than that for the National Office. The remaining responses were "Fair," 21.4%, and "Poor," 7.1%.

Now at the state level, substantially fewer ratings are found, since only 17.6% of these providers indicated they were involved in T/TA needs assessment and planning processes at this level. It can be seen that, of

the 14.6% rating coordination effectiveness with the State Training Office (or its equivalent), 40.0% made positive ratings (excellent and good) and 60.0% made negative ratings (fair and poor).

Finally, coordination effectiveness with the Local Grantee was rated by 26.5% of the 29.4% who were involved with T/TA process at that level. Of these, slightly more respondents gave positive ratings (55.5%) than negative (44.4%).

Another way to recapitulate these findings is to compare the percentage of respondents making positive ratings (excellent, very good, good) about each office of agency. Of those providers who did rate the coordination effectiveness with each office (excluding Don't Know and Not Applicable), the following percentages were positive:

National Office	80.0% (excellent, very good, good)
Regional Office	71.4% (excellent, very good, good)
State Office	40.0% (excellent, very good, good)
Local Grantee	55.5% (excellent, very good, good)

While positive ratings of National and Regional Office coordination effectiveness are comparable with each other, a sharp decline occurs for the State Training Office. Positive ratings for the Local Grantee fall in between the high and low percentages.

b. Regional Level Responses

Regional Level responses on this topic of needs assessment and planning, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1. Regional Office Responses

These responses are further divided into two parts: an aggregated analysis of responses from all 11 regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter on findings.

a) Aggregated analysis of all 11 regions

(See Chapter II for an explanation of the selection process for interviewees in the Regional Offices.)

Initially the 64 regional respondents were asked to specify the criteria by which T/TA needs are determined at the regional level. Of those who responded, the answers given, along with their frequencies, were these:

Table M13: Regional Office Criteria for Needs Assessment

Responses	Frequency
Local Needs Assessment	10
Community Representative Summaries	8
National Objectives	5
Reports of T/TA	4
Analysis of Reports	3
Regional Objectives	2
Other	18

(n = 64, not all of whom answered; also multiple answers were allowed)

Among the responses in the "other" category the most frequently mentioned criteria were previous monitoring reports, previous T/TA projects, and local self-evaluation assessments. Additional criteria listed by only one respondent each included State needs assessments, regional deficiencies, fiscal reports and audit results, State planning group recommendations, RTO suggestions, and intuition.

As a follow-up question, the interviewees were asked to name the participants in the determination of T/TA needs at the regional level. Those persons listed include:

Table M14. Regional Office Participants in Needs Assessment

Responses	Frequency
OCD Director	33
PR&R Specialist	28
RO Specialists	27
ARD	26
RTO/STO	8
Providers	4
Program Specialists (e.g., component coordinator)	4
Grants Manager	3
Consultants	3

(n = 64, not all of whom answered; also, multiple answers were allowed)

Persons listed less than three times included State Director, State Head Start Association, Program staff, parents, community persons, CAP Director, and tribal representatives.

The OCD Director, PR&R Specialists, RO Specialists, and ARD clearly were perceived to have the most direct and integral involvement in assessing T/TA needs. Any others discussed at all received considerably fewer mentions.

The regional interviewees were then asked to change their focus and explain the criteria on which they think local T/TA needs are determined at the local level. The responses given, along with their frequencies, were as follows:

Table M15. Local Criteria for Needs Assessment

Responses	Frequency
National Objectives	5
Community Needs Assessment	1
Regional Objectives	2
Other	7

(n = 64, many of whom did not answer)

Several respondents made the distinction between community needs assessment on the one hand and program or individual needs assessment on the other. Program or individual needs assessment was listed by several respondents under the "Other" category. Also mentioned in the "Other" category were: Performance Standards, e.g., summaries of compliance status on a component-by-component basis; self-assessments; and lastly, informal assessments.

Again, by way of follow-up, regional staff were asked to name those they think are participants in the determination of local T/TA needs. Persons most frequently mentioned were:

Table M16. Local Participants in Needs Assessment

Responses	Frequency
Program Director	14
Program Specialist	14
Program Staff	8
Parents	7
CAP Director	5
Community Person	4
Policy Council	3

(n = 64, many of whom did not answer; also multiple answers were allowed)

Also mentioned were, RTO/STO Community Representative, Regional Office T/TA Committee, and tribal representatives.

After discussing the process and participants involved in determining T/TA needs at the regional and local levels, the respondents were asked to rate the overall effectiveness of the process at both levels. The results of this rating were:

Table M17. Effectiveness of Needs Assessment Process: Regional Office Responses

Level	Effectiveness of T/TA Needs Assessment Process					
	Excellent	Very Good	Good	Fair	Poor	Total
Regional	8	18	9	6	2	43
Local	4	20	9	5	1	39

(n = 64, not all of whom responded)

This table show approximately 81% of the regional staff who answered ranked the effectiveness of the needs assessment process at the regional level as "Excellent," "Very Good," or "Good": only 19% rated the process at "Fair" or "Poor" levels. Rankings of the process effectiveness at the local level resulted in 84% of the responses in the "Excellent," "Very Good," or "Good" categories; only 16% of the regional respondents rated the local needs assessment process at "Fair" or "Poor" levels.

These percentages, even though based on a different number of total respondents at each level, reveal a strong consensus of opinion about the process effectiveness. It should be noted that respondents generally either rated the regional and local level effectiveness in the same category (e.g., "Very Good") or two categories close together on the scale (E.g., "Very Good" and "Good").

Just as the respondents at the national level were asked to discuss how identified needs were prioritized and incorporated into a planning process, so too were the regional office interviewees given similar questions. First, they were asked to explain the process for setting priorities among identified needs at the regional level. Two bases for prioritizing needs were most frequently named: in rank order they are the performance standards and the national objectives. The regional respondents indicated that performance standards requirements are compared against local program performance. Those needs most commonly shared among the local programs receive the greatest attention in the T/TA planning process. The national objectives cover more than just the performance standards and were mentioned less frequently. But the process for prioritizing the needs is similar in that areas of weakness or deficiency are identified to receive the concentrated T/TA effort. In general, the process for setting priorities among the needs at the regional level involves balancing out the common needs of local programs with the regional offices' capability to meet those needs. Other processes

for prioritizing T/TA needs mentioned included use of prioritizing reports, analysis of community representative summaries and T/TA reports.

Once more, the regional interviewees were asked to change their focus to the local level and explain the process for setting priorities among identified needs. By far the most frequently mentioned process was the use of performance standards to determine program component areas in greatest need of improvement. These component weaknesses are revealed in a variety of ways: self-assessments, monitoring reports, and provider reports and recommendations. Other responses included use of national and regional objectives, current crises and local pressure.

Finally, after having discussed in detail how T/TA needs were assessed and prioritized at both the regional and local levels, the interviewees were asked about subsequent T/TA plan development. Among all the responses gathered at the Regional Offices, a rather consistent pattern emerged on the subject of planning for T/TA at the regional level. The results of these findings are presented schematically in Exhibit X. What this exhibit shows is a uniformity among regions in the way they plan for T/TA

All regions responded in one way or another that they take into account national objectives, regional priorities, state and local needs when devising their T/TA plan. Further they rather regularly cited other factors, such as gaps in compliance with the performance standards or special thrusts such as the handicapped policy, as being critical considerations when developing T/TA plans. Some also mentioned that, when setting up their T/TA plans, they weigh input (be it informal or formal) from current T/TA providers, such as information gathered through monitoring.

Such uniformity from one region to the next with regard to T/TA planning seems explainable in large part by the annual T/TA guidance issued by OCD Headquarters. This issuance each year seems to

streamline, from the point of view of the National Office at least, the T/TA plans prepared by each region.

Also evident when all regional responses are aggregated is that basically the same staff are involved in T/TA planning, i.e., OCD Directors (the RPDs), the PR&R Specialists, CRs and/or the Supervisory Community Representatives, other Specialists as appropriate, and the grants management officials. This pattern does have variations from one region to another but overall this grouping regularly seems to have ongoing and primary responsibility for T/TA planning. Sometimes they are organized via task forces or committees. Frequently they are aided by input from associations of Head Start Directors or parents.

By way of summarizing the data on criteria schematically, in addition to Exhibit X, Table M18 has been drawn up for the convenience of the reader:

Table M18: Overview of Regional Office Criteria Utilized in T/TA Needs Assessment, Prioritizing, and Planning at Regional and Local Levels (n=64)

Criteria Mentioned by Respondents / Level	NEEDS ASSESSMENT		NEEDS PRIORITIZING		T/TA PLANNING	
	Regional	Local	Regional	Local	Regional	Local
1 Objectives						
National	X	X	X	X	X	
Regional	X	X		X	X	
2 OCD Guidelines					X	
3 Needs Assessments						
Local						
Needs Assessment	X			X	X	X
Deficiencies			X			
Self-evaluation	X			X		
Community Needs		X				
State Needs	X				X	
Regional deficiencies	X		X		X	
4. Performance Standards		X	X	X	X	X
5 Reports						
Monitoring reports	X			X	X	
CR Summaries	X		X			
T/TA Providers Past)	X		X		X	
T/TA Provider Present	X	X	X	X	X	
Analysis of reports	X		X			
Fiscal reports	X					
6 Other		X				X
Crises				X		
Social pressure				X		
Spec al "houses					X	
handicapped						

EXHIBIT X

COMMON FACTORS IN DEVISING T/TA PLANS AT THE REGIONAL LEVEL

PROCEDURES

- ADDRESS NATIONAL OBJECTIVES
- SET UP REGIONAL PRIORITIES
- MEET STATE NEEDS
  - ANALYZE STATE PLANS
  - RUN TALLIES ON STATE NEEDS
  - VIA LOCAL SELF-ASSESSMENTS
  - DEVELOP REGIONAL PROFILE
- ADDRESS KEY AREAS OF NEED
  - CATALOG & PRIORITIZE ALL IDENTIFIED NEEDS
  - DETERMINE GAPS IN COMPLIANCE WITH PERFORMANCE
  - ARRANGE FOR A COMPONENT BY COMPONENT MEETING OF NEEDS
  - MEET SPECIAL NEEDS
- EVALUATE PROVIDER REPORTS & RESULTS OF MONITORING PROVISION OF T/TA

REGIONAL T/TA PLANNING PROCESS

PARTICIPANTS

- "MANAGEMENT" AT THE REGIONAL OFFICE LEVEL
  - OCD DIRECTORS (RPDs)
  - PRS SPECIALISTS
  - SUPERVISORY CRs
  - COMMUNITY REPRESENTATIVES
  - AREA COORDINATORS
  - FIELD OPERATIONS STAFF
  - PLANNING OFFICERS
  - GRANTS MANAGERS
  - OTHER SPECIALISTS
- T/TA COMMITTEES/TASK FORCES
- CAREER DEVELOPMENT/STAFF DEVELOPMENT COMMITTEES
- ASSOCIATIONS HEAD START DIRECTORS, PARENTS, ETC

This table displays in an integrated overview the discrete items discussed over the past several pages. It shows schematically the importance of various criteria used in needs assessing and prioritizing and T/TA planning on the regional and local levels. It can be seen that, according to respondents, national objectives are considered criteria on all but the local T/TA planning level, while performance standards are indicated for everything but regional needs assessment. (Performance standards are, however, a FY 74 national objective and surely are involved, indirectly at least, in regional needs assessment processes, so it is not precise to think they do not play a role in those processes). Another criterion frequently mentioned by respondents is current T/TA provider reports, which all respondents cited as applicable in every area except local T/TA planning.

After discussing the processes for assessing and prioritizing needs and devising T/TA plans accordingly, the respondents were asked to rate the overall effectiveness of these processes at the regional and local levels. The results of this rating were:

Table M19. Effectiveness of T/TA Planning Process: Regional Office Responses

Level	Overall Effectiveness of T/TA Planning Processes					
	Excellent	Very Good	Good	Fair	Poor	Total
Regional	2	12	10	3	2	29
Local		7	13	3		23

(n = 64, many of whom did not respond)

Of the regional staff who responded, 83% ranked the effectiveness of the T/TA planning process at the regional level as "Excellent," "Very Good," or "Good" and the remaining 17% ranked the proces at "Fair" or "Poor." Effectiveness at the local level was regarded by 87% of the regional respondents to be "Very Good," or "Good," with only 13% of the respondents ranking the local process effectiveness as "Fair" (none ranked it "Poor"). These percentages again reveal marked consensus about the effectiveness of T/TA planning at the regional and local levels.

Next regional staff interviewed were requested to rate the overall effectiveness of the coordination between Headquarters and Regional Offices and between Regional Offices and local programs in relation to needs assessment and planning processes. The results of this rating were:

Table M20. Effectiveness of T/TA Planning Coordination: Regional Office Responses

Levels	Effectiveness of Coordination					
	Excellent	Very Good	Good	Fair	Poor	Total
HQ-RO		4	4	7	6	21
RO-LP	2	4	14	4	1	25

(n = 64, many of whom did not respond)

The table shows that 38% of the respondents to this question rated the coordination between Headquarters and the Regional Office as "Very Good" or "Good" (no respondent answered "Excellent"); 62% rated the coordination either "Fair" or "Poor." In judging the coordination between the Regional Office and local programs, 80% of the regional respondents gave responses of "Excellent," "Very Good," or "Good." Only 20% rated the coordination as "Fair" or "Poor." Obviously, there is a marked difference of opinion about HQ-RO coordination effectiveness as compared to RO-local program coordination effectiveness. The responses imply two things. One, that improvements are needed in the coordinative processes between Headquarters and Regional Offices, and two, that Regional Office personnel generally perceive their coordination efforts with local programs in a positive light. On this latter issue, it must be recognized that the respondents have probable bias in answering this question (as well as in others). The fact that they perceive their efforts so favorably does not invalidate the data; it simply means that the existence of possible bias must be kept in mind in interpreting the data.

Regional Office staff were asked what improvements they could suggest to improve the coordination between HQ-RO in regard to the needs assessment and planning process. Their responses were directed almost exclusively to ways Headquarters could improve:

Table M21. Improvements in Headquarters/Regional Office Planning Coordination

Responses	Frequency
Provided more specific guidance, assistance and information about policies and activities	3
Implement a systematic process for HQ-RO joint planning to permit RO input, review, and comment	3
Produce tools needed (e.g., needs assessment)	2
Issue the T/TA planning guidance earlier	2
Eliminate unnecessary requirements (e.g., elaborate T/TA plans)	2
Be more responsive to RO differences, capabilities, and needs	2
Institute proper planning	1
Have CDTA staff involved in policy and planning meetings	1
Centralize and reduce HQ staff dealing with T/TA activities	1
Increase RO staff	1

(n = 64, many of whom did not answer)

These suggested improvements cover Headquarters organization, planning activities, management and delivery of training and technical assistance, timing, and attitudes toward the Regional Offices.

Then suggestions were elicited for improving coordination between the Regional Office and local programs in regard to the needs assessment and planning processes. The responses for improving these processes were:

Table M22. Improvements in Regional Office/Local Participants Planning Coordination (Regional Office Responses)

Responses	Frequency
Improve structure and coordination in RO (i.e., involve more staff, have planning meetings, etc.)	5
Increase staff in RO	3
Give better guidance to local programs in planning, etc.	2
Give Community Representatives more time to supply local program T/TA needs to RO	1
Incorporate local program self-assessment needs into regional T/TA plan	1
Improve management of providers (e.g., through more on-site visits)	1
Have access to field-tested instruments (e.g., needs assessment)	2
Get HQ policies and guidance earlier	1
Reduce requirements imposed by HQ which limit RO capability to be more involved with local programs	1
Reduce fighting at local level over program control	1

(n = 64, many of whom did not answer)

It is apparent from these responses and their frequencies that the majority of suggestions relate to regional office organization, process, and manpower levels, as opposed to either Headquarters or local program conditions.

Finally, by way of getting another indication of the coordination between the regional and local levels in regard to T/TA planning, respondents were asked whether local programs receive a copy of the Regional Office T/TA Plan. Of the 23 RO staff members who responded to this question, eight indicated that local programs did receive a copy of the RO T/TA plan, 13 said they did not, and two indicated they did not know.

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study" Regional Office on ths subject of T/TA needs assessment and planning. (See Chapter II for an explanation about the selection of the "case studies.")

NEW YORK (II)

In this region the statement of National Head Start Objectives appears to play a pivotal role in the process of T/TA planning. The Regional T/TA Committee tends to help local programs evaluate their T/TA in the light of these nationally set priorities as well as the Regional T/TA plan. On these dimensions the Regional Office and the Regional Training Offices (RTOs) provide definitive leadership for T/TA activities throughout the Region.

The degree of effectiveness of coordination of efforts between Headquarters and the Regional Office in relation to T/TA planning was rated as "Fair" by the Regional Office (on the five point scale of Excellent/Very Good/Good/Fair/Poor). In contrast, the coordination between the Regional Office (including the Regional Training Office) and local programs was rated as "Good." In fact, the Regional Training Office is regarded as a key link in identifying resources to meet local program T/TA needs.

PHILADELPHIA (III)

T/TA needs at the regional level are based on the aggregated local needs assessment and the analysis of compliance by local grantees with the performance standards conducted by the State Training Office (STO), the Community Representative (CR) and the PR&R Specialist.

At the local level, Region III developed a self-assessment instrument by which local programs help determine their own needs. Also; there is community needs assessment. The program staff are involved in T/TA needs assessment at the local level.

At the regional level in Region III, the process for setting priorities of needs is based on performance standards. It is basically a balancing out of the broadest needs with the capability present to meet those needs.

No data was given singling out the process for setting priorities of needs at the local level.

The effectiveness of the T/TA needs assessment process at the regional level was rated as "Very Good" to "Good," with the comment that this rating would be higher if it weren't for the manpower constraints and if there was better consumer input.

The effectiveness of the T/TA needs assessment process at the local level was rated as "Very Good" to "Good."

Several means are employed in Region III to incorporate the results of T/TA needs assessment into sound programming. Local programs develop annual training plans. The PR&R then gets feedback and information regarding these from the STO and plans accordingly. The CRs review these plans with the Regional Office specialists, and providers input is solicited to design final training and technical assistance programs.

The degree to which T/TA plans and services match the actual needs at the regional level was judged to be "Very Good," and at the local level it was rated as "Good."

There is a difference in the rating of the effectiveness of coordination between HQ-RO by the respondents in Region III. One respondent saw it as being "Very Good" but the majority rated it as "Fair" to "Poor" due to time constraints imposed by HQ.

However, all respondents saw the RO-LP coordination as "Very Good," and credited the STOs for keeping regular contact with local programs regarding T/TA.

A comment was made indicating that cooperation between HQ-RO would improve if Headquarters would produce the tools necessary in regard to needs assessment.

Data indicates that local programs do not receive a copy of the Regional Office T/TA plan, but that STOs do and they may share it with local programs.

ATLANTA (IV)

In general, the T/TA Committee operative in this Regional Office performs a pivotal role in the linkage of National and Regional Objectives with local needs assessment data and other information for purposes of T/TA planning. Some sources of information relevant to the entire T/TA needs assessment and planning process are as follows:

- Analysis of local program needs assessment data.
- Analysis of various reports from STOs, LDPs, State Associations, etc.
- Informal and periodic feedback on T/TA activities at the local level.
- Regional Objectives and T/TA Plan.

- National Objectives, Mandates, and Policies.
- Reports of T/TA providers.
- Reports from Community Representatives.

The effectiveness of the T/TA needs assessment and planning process was rated by regional personnel as varying widely; interview responses regarding this effectiveness were given as "Excellent," "Very Good," "Good," and "Poor." It appeared that interviewees were giving their responses on the basis of individual familiarity with specific T/TA projects as contrasted with an overall perception of the totality of the T/TA needs assessment and planning process in the Regional Office.

In consideration of the degree to which T/TA plans and subsequent service do actually meet local needs, the regional staff rated the effectiveness of the planning process at levels of "Good," "Fair," and "Poor." Of significance to this issue is the fact that Region IV has reported extreme delays in receiving CDTA guidance for constructing their T/TA plans for the past two years (FY '74 and FY '75).

The overall effectiveness of the coordination between HQ and the Regional Office regarding T/TA planning was rated by RO staff in the categories of "Good," "Fair," and "Poor." The Regional Office staff saw needed improvements to be additional manpower--particularly at the RO level, and the development of an on-going system of clearly defined roles and responsibilities for input, comment, and review in this communication/coordination process aimed at effecting sound T/TA planning between the two levels.

Likewise, the effectiveness of the coordination between the Regional Office and local programs was rated as "Good" to "Poor." Specific improvements needed as perceived by regional staff were:

- More manpower--again particularly at the regional level.
- More assistance needs to be given to local programs in their planning process.
- CR needs more time to supply the Regional Office with information on local T/TA needs.
- Regional Project Officers need to be more involved in on-site activities.

There was some belief that all local programs did not receive a copy of the Regional Office T/TA plan; there was divided opinion of regional staff as to the opportunity for local programs to comment on or review a draft of the Regional Office T/TA plan before its final form.

CHICAGO (V)

Data in Region V shows a variety of bases on which T/TA needs are determined at the regional level. State needs assessments are used, as well as analysis of fiscal reports, previous monitoring reports, the CR summaries, the amount and complexity of problems needing attention, and finally, what T/TA money was spent on last. The OCD Director, RO Specialists and PR&R Specialist are all involved in the determination of needs at the regional level.

On the local level, community and individual program needs in relation to performance standards are used by a steering committee made up of Head Start program directors, staff, parents, community leaders and executive directors of the CAP program to determine what the local T/TA needs are.

Data from Region V shows that in the past, states have prioritized T/TA needs and passed these to the Regional Office. The RO did not set priorities of T/TA needs as much as they looked at trends to see which areas of needs were most predominant. They looked at the most probable cause of problems that the needs assessment reflects. Regional Office found approaches fell out into

1) management or 2) content skill oriented (e.g., staff didn't have training).

Scant data from Region V does not describe the process for setting priorities among needs at the local level. The only response was that on the local level they "prioritize needs."

The effectiveness of T/TA needs assessment process was rated "Very Good" to "Excellent" on the regional level with the comment that it was limited by amount of available manpower and by the fact the assessment tool available was too complex because it included items over and above performance standards.

The local level needs assessment process was rated as "Excellent" although data was limited.

Results of T/TA needs assessment from state and local grantees are analysed by the Regional Office and approaches to meet the problems are developed and incorporated into a regional plan for T/TA. The people involved with this at the regional level are the OCD Director (RPD), the RO Specialist and the PR&R Specialist.

On the local level, the planning process for incorporating T/TA needs into sound programming is done by a Compliance Steering Committee made up of program staff, directors, parents who develop an improvement plan and have the Regional Office verify it.

Scant data is given rating the effectiveness of T/TA planning matching actual needs, but those responding gave a "Fair" rating on the national level, a "Very Good" rating on the regional level, and a "Good" rating on the local level.

A "Fair" rating was given to the coordination between Headquarters and Regional Office in relation to needs assessment and planning processes. On the RO-LP level, the effectiveness of this coordination was rated as "Excellent."

Various suggestions to improve coordination between HQ and RO included simplifying the present cumbersome T/TA planning process, greater sensitivity of HQ to regional needs as they go through planning process, and clarifying information coming from HQ to RO regarding T/TA activities.

No suggestions were made for improving the "Excellent" RO-LP coordination.

Local programs in Region V do not receive a copy of the Regional Office T/TA plan, although state organizations do, and local programs have access to them in this way.

DALLAS (VI)

The basis for determination of T/TA needs at the regional level include local needs assessments, analysis of regional reports, the Community Representative's reports, reports of the T/TA providers, the national Head Start objectives, the regional Head Start objectives, and suggestions from the RTO and the state planning group.

The people most heavily involved in the determination of T/TA needs at the regional level are the Community Representatives and the PR&R Specialist. Other people also involved are the ARD, the OCD Director (RPD), the RO Specialists, the grants manager and the providers.

T/TA needs at the local level are assessed according to community needs assessment, national objectives, regional objectives, local programs' self-assessments, and performance standards.

The people involved in determining T/TA needs at the local level were understandably those people most closely connected to the programs--the program director, the program specialists, the program staff, the parents and the policy council which is made up primarily of parents.

Priorities at the regional level are set according to performance standards, national and regional objectives, and reflect priorities which come from the local programs themselves. The priorities of needs are then synthesized at the Regional Office.

On the local level, priorities of T/TA needs are set according to where things are weakest in relation to performance standards.

The plan is then worked on by the State Advisory Committee, with the guidance and counsel of the CR and RTO. Efforts are made to assemble the areas of greatest needs by the greatest numbers, and then to formulate a common plan in which these needs can best be met.

The people at the regional level involved in the final synthesis of a uniform T/TA package are those involved in Field Operations, the Planning Department and the grants manager.

Responses from Region VI indicate that T/TA planning effectiveness at the regional and local level is rated as "Very Good" on a scale of Excellent/Very Good/Good/Fair/Poor.

On a scale of Excellent/Very Good/Good/Fair/Poor, the effectiveness of coordination between HQ and RO in relation to needs assessment and planning processes was rated lower than that between RO and the local programs. The latter received ratings of "Excellent" and "Very Good", while HQ-RO was rated as "Very Good" to "Fair." RO staff suggested a lack of understanding exists between Headquarters and the Regional Office, due to the fact that Headquarters CDTA staff does not have the opportunity to sit in on planning and policy meetings and therefore often does not understand completely all factors involved in planning for T/TA indigenous to the region. More communication and a greater effort by HQ to listen to differences and capabilities on the Regional Office level was suggested as a method to increase cooperation in regard to the needs assessment and planning process.

Since coordination and cooperation between the Regional Office and local programs was perceived to be "Very Good" to "Excellent" in relation to the needs assessment and planning process, no improvements were suggested.

Of those respondents who answered the question of whether or not local programs received a copy of the Regional Office T/TA plan, one said "Yes" and one said "No."

SEATTLE (X)

On the regional level in Region X, needs are determined through self-assessment by the grantees and on-site visits of the CR in which compliance to performance standards are reviewed. STATOs then develop work plans which are funneled to and finalized by the PR&R Specialist.

On the local level, the program director, program specialist, staff and parents do a compliance summary and thus identify their program needs to the STATO, who then pass them on to the Regional Office.

At the regional and local level, the process for setting priorities among needs is the same. A tally of all the needs is made and then judged against compliance with performance standards. From this, priorities are set.

The T/TA needs assessment process in Region X was rated as "Very Good" on both the regional and local level. The self-assessment by the grantees was credited with helping the process a great deal.

The PR&R Specialist in Region X combines the state plans submitted by the STATOs and develops a final program plan on the regional level.

On the local level, the Career Development Committee meets together and hammers out local needs in order to devise their program plan, which they pass on to the STATO.

The degree to which T/TA plans and services match the actual needs on the regional level was given a "Very Good" rating, and on the local level was given a "Very Good" to "Good" rating.

There is a difference of opinion as to the effectiveness of the coordination between Headquarters and the Regional Office in relation to needs assessment and planning processes. Most respondents gave this only a "Fair" to "Poor" rating, with the exception of one respondent who judged it to be "Very Good."

On the RO-LP level, there was a general consensus in Region X that the coordination was "Good."

There is a feeling in Region X that the activities that go on between HQ and RO in relation to needs assessment and planning processes are academic exercises and paper planning. RO feels it needs more time to do the planning that is required of them, and suggested a one day meeting involving all regional T/TA personnel to discuss national T/TA policy implementation instead of receiving it in the mail from OCD Headquarters.

The numbers and structure involved in the RO-LP relationship are reported as cumbersome. It was suggested that the needs of local programs, as listed in their self-assessments, be incorporated into the Regional T/TA plan and that this would facilitate and encourage greater cooperation between the Regional Office and local programs.

In Region X, data indicates that local programs do not receive a copy of the Regional Office T/TA plan.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

In the IMPD, T/TA needs are determined by an analysis of reports from the field rating all grantees by means of summaries from Community Representatives, by T/TA provider reports, and by looking at the quantified areas of deficiencies.

On the regional level, the people involved in the needs determination were the OCD Director, the CR to a great extent, the RO Specialists, and the various T/TA providers.

On the local level, T/TA needs are determined according to the local community's own needs assessment. The people involved at this level are the program staff, parents and tribal representatives.

At the regional IMPD level, priorities are set by matching the performance standard requirements against the program's actual performance, and determining from this the areas of greatest needs. National objectives are also taken into account.

At the local level, priorities are set in a wider variety of ways. Performance standards are important; however some priority of needs are set because of local pressure and current crisis.

At the regional IMPD level, the effectiveness of the T/TA assessment process was rated as "Very Good" for the most part, with a small percentage seeing it as only "Fair" on a scale of Excellent/Very Good/Good/Fair/Poor.

On the local level, the rating was more evenly distributed on this scale, with the same number of respondents rating the process as "Very Good," "Good," and "Fair."

On the regional level, the providers themselves are very powerful--they are involved in their own pre-review and monitoring processes. The CR and providers scale and judge the individual programs, and are the people responsible for incorporating the results of T/TA needs assessment into sound programming.

On the local level, the T/TA plan is developed based on identification of needs, the plan is submitted to the T/TA provider, the provider then takes all the plans submitted from his area and develops his own plan. Some providers then choose to distribute the money evenly, while others distribute money according to the plans submitted by the programs.

The program director and staff, as well as the providers, are involved at the local level.

Overall, the effectiveness of T/TA planning was rated highly at both the regional and local levels on a scale that included Excellent/Very Good/Good/Fair/Poor.

There is a wide range of opinion as to how good the coordination is between HQ and IMPD, with a generalized feeling it is "Good," but some respondents seeing it as "Fair" to "Poor."

On the IMPD-LP level, the rating of coordination is better, with all respondents seeing this relationship as "Very Good" or "Good," depending on the effectiveness of the Community Representative.

There is a feeling that if there was more communication, more effort to let the Regional Office know what policies are being developed, coordination between HQ and IMPD would be improved.

On the IMPD-LP level, an increase in staffing which would reduce the grantee/staff ratio and take the load off dependence on one or two people would be an improvement. Increased staffing and increased communication seem to be the biggest factors needed to encourage greater cooperation on all levels.

2. Regional Provider Responses

These responses are also further divided into two parts: group one, 42 respondents from the (generally) most experienced RTO/STO/STATO/OICS network staff across the country, and group two, 77 respondents from a variety of providers: HSST/CDA, LDP, RTO/STO/STATO/OICS, and state multi-state, or region-wide organizations, all of whom were chosen because they serve the local programs selected

in our sample for on-site interviews. This format for presenting regional provider responses will be followed throughout this chapter on findings.

a) Group One: RTO/STO/STATO/OICS network responses (aggregated across all 11 regions).

Presented in this section is an analysis of the responses received from RTO/STO network personnel on the subject of needs assessment and T/TA planning. (See Chapter II for a detailed explanation on the selection process for these individuals.)

Initially, this group of respondents were asked how much improvement they believed necessary in processes for T/TA needs assessment and planning. They were given five choices: a great deal, quite a bit, some, a little, or none. Results of this questioning regarding improvement in T/TA needs assessment and planning were as follows:

Table M23. Improvement Needed in T/TA Needs Assessment/Planning RTO/STO/STATO/OICS Responses (n=42)

Response Categories	Number of Responses	Percent of Total
A great deal	13	31%
Quite a bit	13	31%
Some	13	31%
Little	2	5%
None	0	0
Don't know	1	2%

Apparently 93% of the respondents felt that a discernible need for improvement exists. The differentiation among respondents regarding the extent of the problem is not as arresting as the fact that few people felt that the need was insignificant, and no one felt that no improvement was required. Reactions regarding the degree of need were

mixed within most regions, except Region VIII, in which all respondents indicated that "a great deal" of improvement was in order. In Region IV, seven out of eight respondents indicated substantial need (by checking "a great deal" or "quite a bit"); in Region VI all checked "quite a bit" except one respondent; and in Region VII, all checked "some" except one respondent, who checked "quite a bit."

Next, suggestions were solicited on ways to improve processes for needs assessment and planning. These covered a wide range of ideas. The more frequently mentioned ones are listed below along with the number of times they were mentioned.

Table M24. Suggested Improvements in T/TA Needs Assessment/Planning RTO/STO/STATO/OICS Responses

Responses	Frequency
Provide additional staff	5
Retain current staff for longer periods of time (e.g., prevent high turnover rate by increasing salary level)	5
Develop more and better tools	4
Train staff in use of techniques	4
Allow more time in schedule for performing these tasks	3

(n = 42, not all of whom answered)

Additional suggestions, each mentioned only once, were also given. These included:

- improve community involvement in such processes
- provide more dollars to pay for such processes
- allow RTO/STOs to spend more time on-site helping with follow-up to initial needs assessments
- encourage local grantees to regularly use more planning processes

- urge grantees to incorporate T/TA planning into their overall program planning
- hire better Head Start program directors
- allow Head Start local program directors to practice with and become more proficient at the use of planning processes.

Overall, the suggestions most frequently offered are those relating to staff. Half the responses given recommended upgrading the expertise of the current staff, retaining current staff for longer periods of time, or adding more staff--all in order to improve capability for assessing needs and planning for T/TA.

The respondents then were asked about their own practices regarding the preparation of a T/TA plan. Virtually all (93%) the RTO/STOs interviewed prepare an annual T/TA plan. Similarly, 93% submit a yearly T/TA plan to the Regional Office.

All RTO/STOs except one reported that they coordinate their T/TA activities with the Regional Office. The persons with whom they coordinated were reported as follows:

Table M25. Regional Office Coordinator for RTO/STO/STATO/OICS

Person	Frequency
PR&R Specialist	27
CR	36
RTOs	2
Program (Field) Operations	5
Other	22
TOTAL	93

(n = 42, but multiple answers were allowed)

The "Other" persons mentioned and number of times mentioned were:

Person	Frequency
Team Leader	6
Program Manager	5
Supervisor of Community Representatives	2
Assistant Regional Program Director	2
OCD Director (RPD)	2
Division Director	1
Handicapped Specialist	1
PI Specialist	1
Management Specialist	1
Program Representative	1
TOTAL	22

These RTO/STO respondents were asked if there were any changes they could suggest to improve their relationship with the Regional Office. Of the 26 who expressed some ideas on the subject about one-half indicated an interest in improving communications. Four respondents indicated a need for more communication, six indicated a need for change in the mode of communication, and four indicated a need for "other" improvements.

Next the RTO/STO respondents were asked to suggest any changes to improve their employer relationships (i.e., with the university, agency or private firm involved). Significantly, very few suggestions made here touched on the need for improved communication, in contrast to the clear pattern of RTO/STOs calling for better communications with the Regional Offices. Between RTO/STO/STATO/OICS respondents and their employers the need for better communication did not appear to be a matter of great concern.

This category of respondents was also asked about lateral communication between and among themselves. For example, inquiry was made about whether or not there were meetings for all RTO/STO/STATO/OICS staff in their region for purposes of exchanging ideas and information. Eighty-seven percent of the respondents indicated that there were such meetings for the exchange of ideas and information.

In order to probe the degree of articulation by the Regional Office to members of the RTO/STO network on expectations for their job performance (which would impact on spetific aspects of their job, including those related to needs assessment and planning for T/TA), a question was asked about whether or not lists of specific job objectives were supplied by the Regional Office to RTO/STO officials. The vast majority of respondents indicated that the Regional Office did provide them with a list of objectives related to their role, as can be seen in this table of responses:

Table M26. Availability of Regional Office Objectives to RTO/STO/STATO STATO/OICS (n=42)

Region	Number of Responses		Percent of Responses	
	Positive	Negative	Positive	Negative
II	2	0	100	--
III	5	0	100	--
IV	7	1	87	13
V	5	1	83	17
VI	5	0	100	--
VII	3	1	75	25
VIII	1	2	33	66
IX	2	1	66	33
X	2	1	66	33
IMPD	3	0	100	--
TOTAL	35	7	83	17

A follow-up question was posed on whether or not the direct employers of the RTO/STO network staff also supplied specific job objectives. In contrast to the pattern of affirmative responses regarding regional objectives, training officers were much more divided in their responses when queried whether their direct employers provided them with a list of objectives. Only a minority, 43%, responded affirmatively to that question, as can be seen in this table of responses:

Table M27. Availability of Employer Objectives to RTO/STO/STATO/OICS (n=42)

Region	Number of Responses		Percent of Responses	
	Positive	Negative	Positive	Negative
II	1	1	50	50
III	0	5	--	100
IV	2	6	25	75
V	4	2	66	33
VI	5	1	83	17
VII	2	2	50	50
VIII	3	2	60	40
IX	2	1	66	33
X	1	2	33	66
IMPD	2	1	66	33
TOTAL	18	24	43	57

b) Group Two: Various Regional Provider Responses (aggregate across seven case study regions only)

Presented in this section is an analysis of the responses received from the 77 regional providers on the subject of needs assessment and T/TA planning. (See Chapter II for an explanation of the selection process for these individuals.) Regional variations in these data will be highlighted as appropriate.

Initially, as was the case with the national providers, the regional providers were queried about their involvement in needs assessment and T/TA planning activities at the various levels of Porject Head Start. Positive responses to the questions asking whether or not regional providers were involved in T/TA needs assessment and planning activities at the national, regional, state, and local levels are presented below:

Involved at national level	13.0%
Involved at regional level	59.7%
Involved at state level	68.8%
Involved at local level	77.9%

The figures show a marked increase in involvement at the regional level as compared to the national level. From the regional to the local, the percentage of providers involved steadily increases. Extent of involvement at the regional level is certainly influenced by the degree of information and assistance that each Regional Office wants from regional providers, by the expertise of the individual provider, and by the amount and kind of information available from local programs. At the state and local levels of involvement, a word should be said about those who answered that they were not involved. While the following paragraphs detail this non-involvement on a region-by-region basis, suffice it to say that generally, those not involved at either level tended to be CDA/HSST trainers or coordinators or, to a lesser extent, fiscal, or support staff.

In some instances, regional variations are evident. For example, the only regions in which no providers sampled were involved at the national level were II (New York) and X (Seattle). Those providers who were involved in T/TA needs assessment and planning at the regional level constituted the following proportion of all providers sampled in each region:

Region II (New York)	100.0%
Region III (Philadelphia	85.7%
Region IV (Atlanta)	50.0%
Region V (Chicago)	0.0%

Region VI (Dallas)	50.0%
Region X (Seattle)	66.7%
Region XI (IMPD)	80.0%

With the exception of Region V, the percentages for regional involvement ranged from 50.0% to 100.0%. Regions II (New York), III (Philadelphia), and XI (IMPD) show a high degree of provider involvement in T/TA needs assessment and planning at the regional level. In this past year, Region V introduced a new provider system in some of its states. At the time of the survey there, three states had providers and three other states had no providers. Our sample there included only providers who were under contract at the time of our survey, and all of them responded that they were not involved at the regional level.

At the state level, the percentage of each region's providers indicating involvement was:

Region II (New York	50.0%
Region III (Philadelphia)	50.0%
Region IV (Atlanta)	77.8%
Region V (Chicago)	100.0%
Region VI (Dallas)	85.7%
Region X (Seattle)	55.6%
Region XI (IMPD)	50.0%

An explanation of some figures is necessary. In Regions II, III, IV, X, and XI special conditions pertain. Regions II and III have both region-wide providers and providers who serve only part of a state, so that the answer to our question about involvement at the state level had to be either "No" or "Not Applicable" for half the respondents in each of those regions. In Regions IV and X, most of the respondents who answered "No" or "Not Applicable" were CDA/HSST providers or teacher trainers. Since Region XI does not have the conventional state boundaries that the other regions have, half these providers were not involved in any kind of state T/TA needs assessment and planning process.

No notable differences occurred among regions in regard to involvement at the local level.

As with national providers, regional providers also were asked to indicate which of the criteria from the following list they used to determine their activities. The frequency of "Yes" responses to each criterion is shown in the middle column, and the rank order of each in the right-hand column.

Table M28. Criteria Utilized to Determine Activities of Regional Providers

Criteria Utilized to Determine Provider Activities	Percent of Regional Providers (n=77)	Rank Order of Criteria
National Head Start Objectives	90.9	4
Regional Head Start Objectives	89.6	5
Local Head Start Objectives	93.5	3
Performance Standards	96.1	1
Community Needs	85.7	6
Staff Needs	94.8	2
Volunteer Needs	72.7	8
Parent Needs	90.9	4
Amount of Money Available	77.9	7
T/TA Plan	85.7	6
Part of Grants Application	59.7	9
Contract Requirements	32.5	10
Other Contractors	26.0	11
Other	11.7	12
Not Applicable	1.3	--

NOTE: Compare this table with M6 regarding National Providers.

The three most-frequently mentioned criteria are performance standards (96.1%), staff needs (94.8%), and local Head Start objectives (93.5%). Following closely are two other criteria: national Head Start objectives (90.9%) and regional Head Start objectives (89.6%).

In comparing national provider responses to regional provider responses, both groups named performance standards most often, and staff needs second. While local Head Start objectives were named third most often among regional providers, that criterion placed sixth among national providers.

In looking for possible variations among regions, only two of these criteria revealed differences that are noteworthy. One criterion, "contract requirements," was utilized by only 32.5% of all regional providers sampled (25 out of 77). Seven providers (out of eight) in Region V said this criterion was utilized to determine their activities, and six providers (out of ten) in Region XI (IMPD) indicated the same thing. Thus, just over half of the 25 respondents who answered "Yes" to this criterion were from Regions V and XI. Conversely, only one provider (out of 14) from Region IV (Atlanta) mentioned this criterion. The predominance of Regions V and XI in this criterion is reflective perhaps of the stress given by each of these regions to the contract requirements. It should be noted, however, that contract requirements encompass national and/or regional objectives and that as a result the data in Tables M28 on objectives and contract requirements is not necessarily mutually exclusive.

The other criterion in which marked regional variations occured was "other contractors". Of the 77 providers interviewed, 20 (26.0%) responded that this criterion was utilized to determine their activities. And of these 20 providers, 14 were from Regions IV (six out of 18) and VI (eight out of 14). Between them, these two regions account for 70.0% of those responding "Yes" to this criterion. On the opposite end of the frequency no providers from Region X (Seattle) answered "Yes." Region X posits all its contracts in each State Technical Assistance and Training Office (STATO), so this finding is not surprising. In Region VI, each state has not only at least one Regional Training Office (RTO), but also a State T/TA Grantee. In addition, the Leadership Development Program (LDP) still functions actively in the Region, so activities of other contractors would assume importance for many of the providers in the conduct of their own activities. In Region IV, there is also an LDP, as well as numerous HSST/CDA providers and a couple of regionally-funded providers in special areas, so the requirements of each of those contractors would influence the activities of a number of the Region IV providers.

When regional providers were asked to name the top three criteria, in order of importance, for determining their T/TA activities, the following distribution of responses occurred, displayed here in Table M29:

Table M29. Top-Ranked Criteria for Determining T/TA Activities of Regional Providers (n=77)

Criteria Named for Determining Provider Activities	Percent of Regional Provider Responses			
	First-Ranked	Second-Ranked	Third-Ranked	Aggregate
National Head Start Objectives	18.2%/1	9.1%/4	13.0%/2	40.3%/2
Regional Head Start Objectives	9.1%/3	20.8%/1	14.3%/1	44.2%/1
Local Head Start Objectives	15.6%/2	9/1%/4	11.7%/3	36.4%/3
Performance Standards	15.6%/2	16.9%/2	7.8%/5	40.3%/2
Community Needs	6.5%/4	3.9%/7	9.1%/4	19.5%/6
Staff Needs	5.2%/5	14.3%/3	5.2%/7	24.7%/4
Parent Needs	--	1.3%/9	7.8%/5	9.1%/9
Children Needs	2.6%/7	--	--	2.6%/13
Amount of Money Available	--	1.3%/9	6.5%/6	7.8%/10
T/TA Plan	3.9%/6	5.2%/6	1.3%/10	10.4%/8
Part of Grants Application	--	--	1.3%/10	1.3%/14
Contract Requirements	2.6%/7	1.3%/9	2.6%/9	6.5%/11
Program Needs Assessment and Evaluation	15.6%/2	6.5%/5	1.3%/10	23.4%/5
Provider Self-Assessment and Evaluation	--	2.6%/8	2.6%/9	5.2%/12
Other	3.9%/6	3.9%/7	3.9%/8	11.7%/7
No Response or Not Applicable	1.3	3.9	11.7	--

NOTE: Compare this table with table M4 regarding national providers.

Among the first-ranked criteria, national Head Start objectives placed first (18.2%), performance standards, local Head Start objectives, and program needs assessment and evaluation all tied for second (15.6%), and regional Head Start objectives ranked third (9.1%). Among the second-ranked criteria, regional Head Start objectives was first (20.8%), performance standards was second (16.9%), and staff needs third (14.3%). Among the third-ranked critera, regional Head Start objectives was first (14.3%), national Head Start objectives second (13.0%), and local Head Start objectives third (11.7%). When these rankings are aggregated across each criterion, regional Head Start objectives emerge as first (44.2%), followed by national Head Start objectives and performance standards (each 40.3%), and then local Head Start objectives third (36.4%).

An interesting shift occurs in the importance of regional Head Start objectives from third place in the first-ranked criterion to first place in the second- and third-ranked criteria. Responsiveness to regional objectives is a high priority for regional providers, even though that requirement in no way can be judged as eclipsing either the national objectives or performance standards compared to the national providers sampled, regional providers name the same top three criteria in the aggregate (national Head Start objectives, performance standards, and regional Head Start objectives). Although for the latter group regional rather than national objectives rank first. Regional providers also gave a high ranking to local Head Start objectives; this criterion fell lower in importance for national providers.

No distinct regional variations appeared in the tables ranking criteria.

Regional providers were aksed which of the following resources they utilized for assessing T/TA needs and devising the T/TA plan; the distribution of responses is shown in Table M30:

Table M30. Resources Utilized by Regional Providers for Assessing T/TA Needs and Devising T/TA Plan (n=77)

Type of Resource	Percent of Regional Providers Utilizing Resource
Formal needs assessment tools	79.2
Program Staff evaluation forms	72.7
Program Staff meeting	70.1
Provider reports (RTO/STO/STATO/OICS)	72.7
Other provider reports	46.8
Staff evaluation forms	70.1
Staff meetings	72.7
National Office materials/guidance	80.5
National Office staff (e.g., CDTA, PD&I, etc.)	37.7
Regional Office materials/guidance	85.7
Regional Office staff (e.g., Community Representative)	76.6
Other	32.5
Don't know	--
Not Applicable	1.3

NOTE: Compare this Table with Table M8 regarding national providers.

Notable in this table is the unanimity of response for most of the resources listed. Seven out of the 12 listed had positive responses clustering between 70.1% to 79.2% of regional providers interviewed. Materials and guidance from the national office and the regional office were used by most respondents (80.5% and 85.7%, respectively). Use is greatest of these materials and guidance, of formal needs assessment

tools (79.2%) and of Regional Office staff (76.6%). Least utilized are other provider reports (46.8%), National Office staff (37.7%), and other (32.5%). This "other" category includes responses such as on-site observation, trainee feedback, and community health resources. There does appear to be a slightly greater reliance on written materials, guidance, tools, reports, and forms than on simply personal communications to transmit information.

Some regional variations in these data are obvious. In order to highlight them, Table M31, following this page, has been created to display individual regional responses (positive) on each of these resources.

In Region V (Chicago), only 50.0% of the providers sampled utilized provider (RTO/STO/STATO/OICS) reports and 62.5% used Regional Office materials/guidance and staff. In Region X, only 22.2% utilized provider (RTO/STO/STATO/OICS) reports, 55.6%, regional office materials/guidance, and 3.3%, regional office staff.

Another way to look for patterns among the regions is to calculate the mean percent in each region (total all percentages in a region and divide by the number of resources, 12). All the regions cluster around the 70.0% mark except Regions V and X. These exceptions cannot be accounted for simply on the basis of total number of respondents sampled in each region. Unfortunately, there are too many variables unknown to determine with precision the variances that occur. However, it is obvious that, in terms of certain kinds of resources utilized for T/TA needs assessment and planning, the providers in Regions V (Chicago) and X (Seattle) had different levels of usage than those in other case studies. Perhaps this is because fewer materials, guidance, and staff from the Regional Office were available to them; perhaps it was due to other reasons. In either event, these regional phenomena merit further exploration.

A comparison to national provider responses over the entire spectrum of resources utilized reveals substantive variations on nearly all resources. Those showing a differential ranging from approximately 30% to 43% less use by national providers: program staff and provider staff

Table M31. Percent of Each Region's Providers Utilizing Resources for T/TA Needs Assessment and Planning

Type of Resource	Percent of Each Region's Providers Utilizing Resources						
	II (n=4)	III (n=14)	IV (n=18)	V (n=8)	VI (n=14)	X (n=9)	IMPD (n=10)
Formal needs assessment tools	100.0	78.6	94.4	62.5	78.6	77.8	60.0
Program Staff evaluation forms	75.0	92.9	61.1	75.0	78.6	55.6	70.0
Program Staff meeting	75.0	50.0	77.8	75.0	78.6	66.7	70.0
Provider reports (RTO/STO/STATO/OICS)	100.0	85.7	77.8	50.0*	78.6	22.2*	90.0
Other provider reports	75.0	50.0	61.1	25.0	42.9	44.4	30.0
Staff evaluation forms	75.0	85.7	61.1	62.5	85.7	44.4	70.0
Staff meetings	75.0	64.3	94.4	62.5	71.4	55.6	70.0
National Office materials/guidance	75.0	85.7	88.9	75.0	71.4	66.7	90.0
National Office staff (e.g., CDTA, PD&I, etc.)	50.0	35.7	27.8	12.5	50.0	22.2	70.0
Regional Office materials/guidance	100.0	92.9	94.4	62.5*	92.9	55.6*	90.0
Regional Office staff (e.g., Community Representative	75.0	92.9	88.9	62.5*	71.4	33.3*	90.0
Other	25.0*	28.6*	38.9*	25.0*	42.9*	22.2*	30.0*
Don't Know	--	--	--	--	--	--	--
Not Applicable	--	--	--	--	--	11.1	--
Median percent (total of all percents in each region, excluding "Not Applicable," divided by the number of resources listed: 12)	75.0	70.3	72.2	54.2	70.3	47.2	69.2

evaluation forms; program staff and provider staff meetings; RTO/STO/STATO/OICS and other provider reports; Regional Office materials/guidance; and other. (See Table M61 in local provider discussion of this issue for complete tabular recapitulation.)

These regional providers were then asked if they prepared a written T/TA plan or work statement for their activities. The responses formed this distribution:

Yes	92.2%
No	5.2%
Not Applicable	2.6%

Comparing these responses to those of national providers reveals a notable differential: 92.2% compared to 64.7%.

Those regional providers who answered "Yes" were then asked to specify to whom and how often they submitted their T/TA plans or work statements. Table M32 presents this data:

Table M32. Percent of Regional Providers Submitting Written T/TA Plan Work Plan to Organization or Agency and Frequency of Submission (n=77)

Recipient of T/TA Plan	Percent of Regional Providers Submitting Plan	Frequency of Submission				
		Monthly	Quarterly	Semi-Annually	Annually	Othe
Employer	31.2	9.1	7.8	--	13.0	1.3
Policy Advisory Board	20.8	5.2	3.9	1.3	9.1	--
Grantee Board	11.7	3.9	2.6	--	5.2	--
State T/TA Grantee	24.7	3.9	3.9	--	14.3	2.6
Regional Office	72.7	10.4	16.9	1.3	37.7	6.5
National Office	7.8	--	1.3	--	6.5	--
Part of Grants Application	22.1	--	1.3	--	20.8	--
Part of Contract Requirements	3.9	--	--	--	3.9	--
Other	22.1	3.9	2.6	--	11.7	3.9

NOTE: All percentages are based on the total number of respondents. Compare this Table with Table M9 regarding national providers. Because this question was designed to permit multiple responses for the recipient part only, no recipient percent totals 92.2%, the number of respondents answering "Yes" to the preceding question. Respondents were allowed to indicate only one frequency for each recipient and all percentages in each frequency row but one (Policy Advisory Board), total the recipient percent listed in the second column. The discrepancy for Policy Advisory Board is caused by the respondent not knowing the frequency.

Most respondents answered that plans were submitted to the Regional Office (72.7%). The percentages for other categories of recipients declined sharply: employer (31.2%); state T/TA grantee (24.7%); part of grants application and other (each 22.1%); and Policy Advisory Board (20.8%). The category "other"refers to either T/TA director or the Head Start director. The frequency category "other" included the responses "on-going," "each time training is done," "upon request," "weekly," "contract period," and "submitted when I do a case study for each agency."

These frequencies of submission to the Regional Office reveal some differences among regions. All the respondents who specified "monthly" were from Region VI (Dallas). This group of eight represented 57.1% of all Region VI providers interviewed. Regarding frequency of submission of T/TA plan, the predominant pattern is that such plans were turned in annually, although to the Regional Office some respondents submitted plans monthly (10.4%), quarterly (16.9%), semi-annually (1.3%), or most commonly, annually (37.7%).

This frequency of T/TA plan submission may indicate a close accountability and monitoring effort for some T/TA providers.

Then, as with the national providers, these respondents were asked, "how effective is the process you use to assess the T/TA needs and devise your T/TA plan?" Their answers appear below in Table M33:

Table M33. Effectiveness of Regional Providers' T/TA Needs Assessment and Planning Processes (N=77)

Categories of Responses	Percent
Excellent	20.8
Very Good	48.1
Good	24.7
Fair	3.9
Poor	
Not Applicable	2.6

NOTE: Compare this Table with Table M10 regarding national providers).

When the first three categories (Excellent, Very Good, and Good) are aggregated, the total is 93.6% of regional provider respondents. This figure represents a higher positive effectiveness rating than national providers gave (79.5%).

Some regional variations do exist in responses to the effectiveness rating considering only the highly positive responses (excellent and very good) given by providers in each region, the percentages on a re-region-by-region basis are:

Region II (New York)	100.0% Excellent/Very Good
Region III (Philadelphia)	71.4% Excellent/Very Good
Region IV (Atlanta)	61.1% Excellent/Very Good
Region V (Chicago)	87.5% Excellent/Very Good
Region VI (Dallas)	71.4% Excellent/Very Good
Region X (Seattle)	33.3% Excellent/Very Good
Region XI (IMPD)	80.0% Excellent/Very Good

Fewer providers in Regions IV and X feel their T/TA needs assessment and planning process is very good or excellent than providers in the other regions. Region X providers gave highly positive ratings least frequently of any region (33.3% of the time). This finding may tie in with the relatively lower use by Region X providers of resources for T/TA needs assessment and planning shown in Table M31 (median percent, 47.2%). The comparison of figures from that table and these effectiveness ratings suggests that these differences may be due to the particular structure and function of Region X's provider system. Recall that providers in Region V (Chicago) also revealed a relatively lower use of resources (median percent, 54.2%), yet 87.5% gave highly positive ratings for the T/TA needs assessment/planning effectiveness rating. Or, on the opposite side of the coin, perhaps Region X providers generally were more frank than other regional providers.

As happened at the national level, the providers tend to rate the effectiveness of T/TA needs assessment and planning processes more favorably than OCD personnel on the regional level.

To recapitulate on this subject-------

Level	Officials OCD		Providers T/TA
National Level	General "fair"	vs.	79.5% "Excellent, Very Good, Good."
Regional Level	83% "Excellent, Very Good, Good."	vs.	93.6% "Excellent, Very Good, Good."

What this shows again is that OCD officials tend to be less satisfied (especially those at headquarters) with needs assessment and T/TA planning than the providers of T/TA. It is true that conceivably they are closer to the "firing line" and that as a result their perceptions might

be more accurate; but it is also true that they have more to gain by giving more favorable responses than the officials.

Next, these regional providers were queried as to how much improvement they thought was necessary in these processes. On this subject of improvement needed, they gave the following responses:

Table M34. Extent of Improvement Needed in Regional Providers' T/TA Needs Assessment and Planning Processes (n=77)

Responses	Percent
A Great Deal	8.5
Quite a Bit	7.8
Some	62.8
A Little	18.2
None	2.6
Not Applicable	2.6

NOTE: Compare this Table with Table M11 regarding national providers.

Well over a majority indicated only "Some," while those who perceived more than "Some" improvements needed (i.e., "A Great Deal or Quite a Bit") totaled 14.3%, and those little or none, 20.8%. These responses vary from those of the national providers in that more regional providers (62.8% vs. 47.1%) answered "Some."

Comparing these results of the providers' interviews with those of the regional office staff is difficult. The latter gave specific suggestions for improvement without saying how much improvement was needed, whereas the provider here have suggested how much improvement they feel is needed at the regional level without specifying how to achieve it. Check Tables M21 and M22 for the RO staff responses on this subject.

After having discussed their perceptions on various aspects of needs assessment and T/TA planning processes, these regional providers were asked to rate the effectiveness of the coordination, in terms of planning for T/TA at the local level, between their organization and each of the these offices: the National Office; the Regional Office; the State Training Office (or its equivalent); and the local grantee. As was discussed in the national provider section, in order to offer a rating for any one of these groups, each respondent had to be involved in the needs assessment process for T/TA at that particular level, and this information was known because of a previous question asked. The answers from that previous question are presented again here for reference:

Level of Involvement by Regional Providers in T/TA Needs Assessment and Planning Process	Percent of Regional Providers Involved
National Level	13.0
Rational Level	59.7
State Level	68.8
Local Level	77.9

With those respondents who were involved in the T/TA needs assessment and planning at any one of those levels, the appropriate rating question was then asked.

Table M35 shows the responses to each question of only those who reported a rating on the effectiveness of coordination:

Table M35. Percent of Regional Providers Rating Effectiveness of Coordination in T/TA Planning at the Local Level Between Their Organization and the National Office, Regional Office, State Training, and Local Grantee

Rating	Percent of Regional Providers Effectiveness of Coordination with Each Office			
	National Office	Regional Office	State Training Office	Local Grantee
Excellent	00.0%	26.7%	30.8%	22.0%
Very Good	30.0%	31.1%	30.8%	54.2%
Good	30.0%	33.3%	11.5%	13.6%
Fair	30.0%	8.9%	23.1%	8.5%
Poor	10.0%	0.0%	3.8%	1.7%
n =	11/77	45/77	26/77	59/77
Not Reported =	66	32	51	18

Of the 13.0% of regional providers who were involved in the T/TA needs assessment and planning process at the national level, all rated coordination effectiveness of their provider organization with the National Office in terms of planning for T/TA at the local level. (Recall the discussion in the section on national providers about the phrasing of this question deliberately chosen because of our assumption that most T/TA planning ultimately effects local Head Start programs.) It can be seen that no one used the rating "Excellent," that the other positive responses (very good and good) combine to 60.0% of these responses, and the negative responses (fair and poor) total 40.0%.

All respondents who were involved in the T/TA needs assessment and planning process rating coordination effectiveness with the Regional Office. Most (91.1%) gave positive ratings (excellent, very good, good).

In fact, nearly three-fifths of these ratings (57.8%) were in the excellent (8.9%) rated coordination effectiveness as "Fair" or "Poor."

Involved in T/TA needs assessment and planning process at the state level were 68.8% of all regional providers interviewed. When it came to rating coordination effectiveness with the State Training Office (or its equivalent), a number of those involved answered "Not Applicable," because they were the State Training Office. Therefore, the percentage of these respondents giving this particular rating dropped to 33.8% of all the possible respondents. An equal number of providers rated coordination effectiveness "Excellent" and "Very Good" (30.8%). The next highest percent was 23.1%, rating it "Fair." The positive ratings totaled 73.1%; the negative ratings, 26.9%.

Of the 77.9% of regional providers involved in T/TA needs assessment and planning at the local level, two did not rate coordination effectiveness with the Local Grantee. But, of the remainder, the majority (54.2%) rated it as "Very Good," and another 22.0% said "Excellent." The total of positive responses is 89.8%; negative responses are a very low percent, 10.2%.

To present these findings in another way, positive responses for coordination effectiveness between the provider organization and each office or grantee totaled the following percentages of all respondents making a rating (excluding Don't Know and Not Applicable): National Office, 60.0%; Regional Office, 91.1%; State Training Office (or its equivalent), 73.1%; and Local Grantee, 89.8%.

The positive ratings calculated the same way for national providers were: 80.0%; 71.4%; 39.7%; and 55.5%. Considerable variations between the two providers groups occur in these figures.

c. Local Level Responses

Local level responses on this topic of needs assessment and planning for T/TA, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of Directors staff, parents, and community leaders (where appropriate) associated with the 30 Head Start programs sampled and then from that of local level T/TA providers.

1. Local Program Responses

Project staff interviewed a total of 428 directors, staff, and parents. (See Chapter II for an explanation of the selection process utilized.)

These various Directors, staff, parents were questioned about the criteria they followed when assessing T/TA needs and planning accordingly. First they were asked whether or not they employed certain criteria. Of the 428 responses, the frequencies were:

Table M36. Criteria Used for Assessing Local T/TA Needs (Directors, Staff, and Parents) (n=428)

Ranking	Criteria	Percent Yes
First	Parent needs	71.5%
Second	Staff needs	68.2%
Third	Local objectives	65.9%
Fourth	Community needs	65.4%
Fifth	Performance standards	58.9%
Sixth	National objectives	54.0%
Seventh	Volunteer needs	51.9%
Eighth	Available Money	48.1%
Ninth	Regional objectives	47.7%

NOTE: Compare this Table With Table M13 regarding regional criteria.

It seems apparent that, in terms of frequency of response, more weight is given by this group of respondents to meeting parent and staff needs, local objectives, and community needs. It also seems that local objectives are used more as criteria for assessing T/TA needs than regional or national ones. However, the data does not allow for the possibility that local objectives might well be, in some cases at least, restatements of regional or national ones.

Second, on the subject of criteria for assessing needs and devising T/TA plans, the Director, staff, and parents were asked to list the top three criteria they used for this purpose. The results in tabular form are:

Table M37. Top Three Criteria for Assessing Local T/TA Needs (n=428)

Criteria	First Priority Rank Order	First Priority Percent Yes	Second Priority Rank Order	Second Priority Percent Yes	Third Priority Rank Order	Third Priority Percent Yes
National Objectives	6	(8.7%)	8 tie	(4.1%)	8	(3.2%)
Regional Objectives	9	(4.8%)	8 tie	(4.1%)	9 tie	(2.5%)
Local Objectives	7	(6.9%)	5	(8.5%)	4	(11.6%)
Performance Standards	2	(16.1%)	4	(9.8%)	5	(9.8%)
Community Needs	4	(10.4%)	3	(13.6%)	3	(14.7%)
Staff Needs	1	(17.6%)	1	(23.1%)	2	(17.5%)
Volunteer Needs	12	(0.6%)	11	(1.9%)	7	(5.6%)
Parent Needs	3	(13.1%)	2	(22.2%)	1	(19.3%)
Children Needs	5	(9.0%)	6 tie	(4.4%)	12 tie	(1.1%)
Available Money	8	(5.4%)	6 tie	(4.4%)	6	(9.5%)
In-House Evaluation	10	(4.2%)	12	(0.3%)	11	(1.8%)
Other	11	(3.3%)	10	(3.5%)	9 tie	(2.5%)
Resources Available					12 tie	(1.1%)
		100%		100%		100%

What this data shows is that virtually the same top five criteria show up in each column as most used in assessing local needs and devising T/TA plans as in the previous table. In other words, when respondents were asked which criteria they used and then to list the top three, the results were very similar. To illustrate this, Table M38 has been constructed:

Table M38. Comparison of Data Sources on Criteria for Needs Assessment

Criterion	Straight Frequency (M36) vs. Prioritized Frequency (M37) Ranking	Ranking (weighted*)
Staff Needs	Second	First
Parent Needs	First	Second
Performance Standards	Fifth	Third
Community Needs	Fourth	Fourth
Local Objectives	Third	Fifth

Staff needs and parent needs ranked first or second both times; performance standards and local objectives scored third and fifth one time each; and community needs came out in fourth place both ways. What is significant is not so much the individual positions but that these five criteria consistently were mentioned most often as applicable in needs assessment.

As far as differences among the seven case study regions are concerned, respondents in two regions placed great emphasis on performance standards as a criterion for assessing needs and devising T/TA plans. The "national norm," i.e., the percent of all respondents across the seven regions who mentioned the performance standards as a criterion

*The weighting was done in order to integrate the results of three separate listings or columns contained in M37, one each for first, second, and third priority.

was 58.9%. However, in Region II New York, the percentage was 66.7% and, in Region IV Atlanta, the figure was 69%. Region VI Dallas, on the contrary, mentioned this criteria only 40.4% of the time. Apparently, the programs sampled in New York and Atlanta place more emphasis on this particular criterion than those in other case studies, while programs sampled in Dallas place less on it than others.

One of the criterion that did not get mentioned often enough to be considered one of the top five was "availability of money." Only 48% of all respondents mentioned this at all, meaning that it was near the bottom in the list of criterion employed. However, programs in two regions placed exceptional emphasis on this criterion: Region V Chicago where 71.4% of the respondents (63) mentioned it and Region II New York, where 66.7% of those interviewed (48) listed it as a criterion they utilized.

These findings relative to performance standards and available money as criteria for assessing needs and devising T/TA plans derive from the tabulation of frequencies of mentioning lists of criteria that are used. As mentioned above, all respondents were also asked to prioritize their criteria, i.e., to list the top three they employ for assessing needs and planning for T/TA. This should provide, in theory, more refined results. Among the differences detected among regions using this technique were these:

- The "norm" across all regions sampled for using staff needs as a top priority criterion to assess needs and plan accordingly for T/TA was a 17.6% rate of response; our sample Regions II (25%) and X (23.3%) exceeded that rate of response significantly, i.e., they seemingly stress this criterion more when assessing needs and devising T/TA plans.
- The "norm" across all regions sampled for using parent needs as a top priority criterion to assess needs and plan for T/TA was a 13.1% rate of response; Regions III (20%) and V (21.6%) exceeded that rate of response significantly.

- The "norm" across all regions sampled for using performance standards as a top priority criterion to assess needs and plan for T/TA was a 16.1% rate of response; Regions II (25%) X (23.3%), and IV (20.4%) all exceeded that.

All respondents were then read a list of resources that conceivably could be used as aids in assessing needs and devising T/TA plans and asked which particular ones they used. The results are displayed in the following table:

Table M39. Resources Utilized by Local Programs in Assessing Needs and Devising T/TA Plans (Director, Staff, Parent Respondents, n=428)

Resources	Percent of Positive Responses
Formal Needs Assessment Tools	39.3%
Staff Evaluation Forms	54.2%
Staff Meetings	67.3%
RTO/STO Network Reports	36.4%
Other Provider Reports	12.1%
RO Materials/Guidance	45.3%
RO Staff (e.g., CR)	32.2%
Others	11.0%

These findings indicate that the largest number of respondents (67.3%) mentioned staff meetings as a useful resource in assessing needs and devising T/TA plans. Next most frequently mentioned was the use of staff evaluation forms (54.2%), followed by Regional Office Materials or Guidance (45.3%) and then Formal Needs Assessment Tools (39.3%).

One significant variation in an individual region, occurred in Region II New York, where only one out of 48 respondents or 2.1%) (as opposed to the "norm" of 12.1% arrived at by aggregating all responses across the seven regions) reported that they used reports of other

providers (non-RTO/STO network) as a resource. This represents an exception to the pattern of the other regions.

Next on the subject of assessing needs and devising T/TA plans, all respondents were asked whether or not they identified specific program improvement areas (e.g., nutrition) as part of their T/TA planning efforts. The tabulation of the frequencies of response to this question is presented here in Table M40, following this page.

The results shown here indicate a strong pattern across all seven case study regions to identify improvement areas--four out of every five respondents answered affirmatively.

Region X Seattle respondents (55) had the highest percentage of affirmative responses--89.1% ("norm"--79.9%), while Region V Chicago respondents (45) had the highest percentage of negative responses--14.3% ("norm"--5.8%)

A second form of analysis of this data would involve the cross-tabulation of these results with data obtained regarding the level of satisfaction with T/TA received by these same respondents. An assump-

Table M40. Identification of Program Improvement Areas by Local Programs (n=428)

IMPRPLAN	REGION	REGN II (2.)	REGN III (3.)	REGN IV (4.)	REGN V (5.)	REGN VI (6.)	REGN X (10.)	REGN XI (11.)	ROW TOTAL
1. YES	COUNT	39	61	60	45	39	49	49	342
	ROW PCT	11.4	17.8	17.5	13.2	11.4	14.3	14.3	79.9
	COL PCT	81.3	78.2	84.5	71.4	75.0	89.1	80.3	
	TOT PCT	9.1	14.3	14.0	10.5	9.1	11.4	11.4	
2. NO	COUNT	1	6	4	9	1	0	4	25
	ROW PCT	4.0	24.0	16.0	36.0	4.0	0.0	16.0	5.8
	COL PCT	2.1	7.7	5.6	14.3	1.9	0.0	6.6	
	TOT PCT	0.2	1.4	0.9	2.1	0.2	0.0	0.9	
8. DON'T KNOW	COUNT	7	8	6	9	11	1	8	50
	ROW PCT	14.0	16.0	12.0	18.0	22.0	2.0	16.0	11.7
	COL PCT	14.6	10.3	8.5	14.3	21.2	1.8	13.1	
	TOT PCT	1.6	1.9	1.4	2.1	2.6	0.2	1.9	
9. NOT APPL	COUNT	1	3	1	0	1	5	0	11
	ROW PCT	9.1	27.3	9.1	0.0	9.1	45.5	0.0	2.6
	COL PCT	2.1	3.8	1.4	0.0	1.9	9.1	0.0	
	TOT PCT	0.2	0.7	0.2	0.0	0.2	1.2	0.0	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

tion is being made here that these two factors might well be interrelated. This cross-tabulation is displayed here in Table M41.

Table M41. Cross-Tabulation: Satisfaction vs. Identifying Improvement Areas (n=354)

	TTASATIS				
	COUNT / ROW PCT / COL PCT / TOT PCT	VERY SATISFIED	SATISFIED	DISSAT-VERY DIS	ROW TOTAL
		30.1	31.1	32.1	
IMPRPLAN					
YES	1.	104	180	49	333
		31.2	54.1	14.7	94.1
		92.0	94.7	96.1	
		29.4	50.8	13.8	
NO	2.	9	10	2	21
		42.9	47.6	9.5	5.9
		8.0	5.3	3.9	
		2.5	2.8	0.6	
COLUMN TOTAL		113	190	51	354
		31.9	53.7	14.4	100.0

This table shows that, apparently, no significant variation in T/TA satisfaction occurs between those who identify specific program improvement areas in devising T/TA plans and those who do not. However, the number of respondents who do not is so small as to make any meaningful comparison very difficult.

Another cross-tabulation of this data regarding the identification of particular improvement areas that seemed appropriate was with the impact these same respondents perceived T/TA was having on their program. Again, the assumption was that these two factors might well be interrelated. This cross-tabulation is shown here in Table M42.

Table M42. Cross-Tabulation: Impact vs. Identifying Improvement Areas (n=349)

IMPRPLAN	TTAEFFCT: A GREAT IDEAL	QUITE A BIT	SOME	A LITTLE	NONE	ROW TOTAL
1. YES	106	102	93	28		329
	32.2	31.0	28.3	8.5		94.3
	97.2	91.9	93.9	93.3		
	30.4	29.2	26.6	8.0		
2. NO	3	9	6	2		20
	15.0	45.0	30.0	10.0		5.7
	2.8	8.1	6.1	6.7		
	0.9	2.6	1.7	0.6		
COLUMN TOTAL	109	111	99	30		349
	31.2	31.8	28.4	8.6		100.0

As with the previous contingency table on satisfaction, this data seems to show no difference regarding perceived impact that T/TA had between those who identified specific T/TA improvement areas and those who did not. Once more, the number who did not is very small; hence, the making of any useful comparisons is difficult.

Then the various Directors, staff, and parents interviewed were asked who specifically in their program is directly involved in determining local T/TA needs and devising the T/TA plan. The answers given are presented here in a tabulation of simple frequency of response.

Table M43. Participants in Needs Assessing and T/TA Planning (Directors, Staff, Parents, n=428)

Participant	Percent of Positive Responses
Director	78.5%
Staff	74.1%
Teachers	62.9%
Education Coordinator	52.3%
Health Coordinator	50.7%
Social Service Coordinator	45.6%
Parent Involvement Coordinator	51.9%
Career Development Coordinator	40.4%
Aids	42.3%
Volunteers	29.4%
Other Staff	12.1%
Parents	52.3%
Grantee Board	20.1%
Policy Advisory Council	46.0%
Others	10.5%

As would be expected, according to these data, the Director (78.5%) and staff (74.1%) were perceived as being most involved in the assessing of needs and devising T/TA plans. And among staff, teachers (62.9%) were perceived by the respondents as being very directly involved in these processes. After that both the education coordinators and the parents (both 52.3%) were mentioned most frequently.

In terms of regional differences, several noteworthy items manifested themselves:

- Region II New York respondents (48) mentioned staff involvement in needs assessing and T/TA planning 87.5% of the time, Region VI Dallas, 86.5%, both considerably above the national "norm" frequency of 74.1%.
- Region II New York interviewees mentioned parent involvement in these processes 75% of the time, way above the aggregated national frequency of 52.3%, meaning that in the view of those sampled parents are more actively involved in these procedures in Region II than in the other case study regions.
- Region X Seattle respondents (61) mentioned the involvement of Policy Advisory Councils (PACs) 61.8% of the time, above the percentage of 40.0% for all respondents interviewed in the regions sampled.
- All responses taken together (428) indicate that teachers were perceived to be involved 62.9% of the time in these matters; however, in two regions, the involvement of teachers was apparently thought to be greater--Region II New York (83.3% frequency of response) and Region X Seattle (80%).
- Region II New York also mentioned the involvement of educational coordinators more often (62.5% of the time) than the national "norm" of 52.3% frequency of response.
- Region II New York further mentioned the involvement of health coordinators 75% of the time, significantly above the 50.7% "national norm" frequency tabulated when all responses are aggregated; Region X Seattle listed health coordinators' involvement 67.3% of the time, also a noteworthy exception to the national "norm" of 50.7%.
- Region II New York respondents likewise mentioned involvement of aides 66.7% of the time, a greater frequency of response by far than the aggregated "norm" of 42.3%

- Finally, Region II New York respondents said 50% of the time that volunteers were involved, considerably greater a frequency than the national "norm" of 29.4% gathered by aggregating the responses from all seven case study regions.

The most noteworthy fact that emerges from this recounting of regional differences on the subject of who participates at the local program level in assessing needs and devising T/TA plans is that Region II New York respondents report considerably greater involvement of several categories of personnel, namely parents, and staff generally, and more particularly, teachers, educational, and health coordinators, and aides and volunteers. It seems possible to conclude from these findings that greater emphasis was placed on involvement of more categories of personnel in the T/TA needs assessment and planning processes in Region II programs sampled than the other six case study regions.

The question of whether or not T/TA providers themselves are involved in needs assessing and/or T/TA plan devising was then put to each respondent. Their answers are shown here in Table M44, following this page.

More than one-half of these respondents (54.0%) reported that they thought providers were involved in needs assessment and T/TA planning processes. Only one-fifth (20.3%) of this group of interviewees said T/TA providers were not involved in these processes.

Two regions show greater involvement of T/TA providers in these processes than the "norm" (54.0%): Region II New York with a frequency of 64.6% and Region IV Atlanta, with a frequency of 63.4%.

Table N44. Involvement of Providers on Needs Assessment and T/TA Plans
(Directors, Staff, Parents, n-428)

PROVPLAN	REGION	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	COUNT	2.	3.	4.	5.	6.	10.	11.	
YES	1.	31	35	45	29	31	26	34	231
	ROW PCT	13.4	15.2	19.5	12.6	13.4	11.3	14.7	54.0
	COL PCT	64.6	44.9	63.4	46.0	59.6	47.3	55.7	
	TOT PCT	7.2	8.2	10.5	6.8	7.2	6.1	7.9	
NO	2.	12	21	12	18	10	8	6	87
	ROW PCT	13.8	24.1	13.8	20.7	11.5	9.2	6.9	20.3
	COL PCT	25.0	26.9	16.9	28.6	19.2	14.5	9.8	
	TOT PCT	2.8	4.9	2.8	4.2	2.3	1.9	1.4	
HOPE, SD	3.	0	0	0	1	0	0	0	1
	ROW PCT	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.2
	COL PCT	0.0	0.0	0.0	1.6	0.0	0.0	0.0	
	TOT PCT	0.0	0.0	0.0	0.2	0.0	0.0	0.0	
DON'T KNOW	8.	5	20	14	13	11	17	20	102
	ROW PCT	4.9	19.6	13.7	14.7	10.8	16.7	19.6	23.8
	COL PCT	10.4	25.6	19.7	21.0	21.2	30.9	32.9	
	TOT PCT	1.2	4.7	3.3	3.0	2.6	4.0	4.7	
NOT APPL	9.	0	2	0	0	0	4	1	7
	ROW PCT	0.0	28.6	0.0	0.0	0.0	57.1	14.3	1.6
	COL PCT	0.0	2.6	0.0	0.0	0.0	7.3	1.6	
	TOT PCT	0.0	0.5	0.0	0.0	0.0	0.9	0.2	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

Next the respondents were asked to specify which providers were involved. Their aggregated responses are displayed in Table M45.

Table M45. Involvement of Particular Kinds of Providers (Director, Staff, Parent Respondents, n=428)

Provider	Percent of Positive Responses
State T/TA Grantee	16.6%
RTO/STO Network	31.8%
Public Schools	12.1%
Universities and Colleges	20.6%
Public Agencies	22.4%
Private Agencies	6.8%
Private Companies	3.7%
Churches	5.8%
Private Consultants	13.6%
Others	7.0%

The tabulating of the data in this way indicates that the RTO/STO Network is the single category of provider of T/TA most involved in assessing needs and planning for T/TA at the local level.

However, examining the data more closely results in some regional differences:

- Regions VI Dallas (32.7%), V Chicago (28.6%), and IV Atlanta (22.5%) use state T/TA grantees for this purpose more than the "norm" which is 16.6% of the time if all responses (428) are aggregated.
- Region VI Dallas uses its RTO system for this purpose considerably more frequently (44.2%) than the "norm" of 31.8% according to those interviewed.

- Region II New York uses the help of its public schools more frequently (27.1%) than any other region studied and more often than the "norm" of 12.1%.
- Region V Chicago seems to have more frequent involvement of universities or colleges (31.7% frequency of response) than the "norm" of 20.6%.

Another facet of the needs assessment and T/TA planning process at the local level that KAI field staff examined was that of who makes the final decision in these matters. Not surprisingly, Head Start Directors were mentioned most frequently. The responses break out this way:

Table M46. Final Decision Makers in T/TA Needs Assessing, Planning (Director, Staff, and Parent Respondents, n=428)

Decision Maker	Percent of Positive Responses
H.S. Grantee Director	34.3%
H.S. Director and Policy Council Coordinator	11.4%
H.S. Delegate Agency Director	8.9%
H.S. Director and Grantee	0.9%
H.S. Director and AC	5.6%
H.S. Director and Staff	4.9%
H.S. Director for Center	1.6%
Executive Director of Grantee/Delegate Agency	5.3%
TOTAL	72.9%

The data supports the conclusion that the H.S. Director or Executive Director of the Grantee or Delegate Agency either alone or jointly was involved in the final decision making regarding T/TA needs assessments and plans 72.9% of the time, according to the various Directors, staff, and parents interviewed across the seven case study reguions.

Then, as with OCD Headquarters officials and Regional Office staff persons interviewed, these directors staff and parents were asked to rate the overall effectiveness of the process employed at their local program level to assess T/TA needs and devise their T/TA plan. Table M47 follows this page.

Seventy-seven percent (77.3%) of the respondents rated the effectiveness as Excellent, Very Good, or Good. Only 8.2% said Fair or Poor. Recall that when regional office respondents were asked to rate the effectiveness of local level needs assessment, 84% said Excellent, Very Good, or Good and 16% said Fair or Poor; and that is when those same respondents were asked to rate separately the effectiveness of local T/TA planning, 87% said Excellent, Very Good, or Good, and 13% said Fair or Poor. This seems to indicate similar perceptions from both levels regarding the effectiveness of local level needs assessment and T/TA planning processes.

The 77.3% represents the total of respondents in all seven case study regions who answered Excellent, Very Good, or Good. Two individual regions whose respondents answered this question showed exceptional results compared to the "national" figure of 77.3%: Region IV Atlanta respondents (71) answered Excellent, Very Good, or Good, 88.7% of the time, and Region VI Dallas respondents (52) 82.7%, indicating that those interviewed in these regions seem to feel their needs assessment and T/TA planning processes were more effective than in the other five regions sampled.

Table M17. Effectiveness of Local Program Needs Assessment and IPA Planning Processes (Director, Staff, Parent Respondents, n=428)

PROCEFF	REGION	REGN II 2.1	REGN III 3.1	REGN IV 4.1	REGN V 5.1	REGN VI 6.1	REGN X 10.1	REGN XI 11.1	ROW TOTAL
EXCELLENT	10.	4	9	16	11	3	8	5	56
		7.1	16.1	28.6	19.6	5.4	14.3	8.9	13.1
		8.3	11.5	22.5	17.5	5.8	14.5	8.2	
		0.9	2.1	3.7	2.6	0.7	1.9	1.2	
VERY GOOD	11.	14	30	25	18	28	16	13	144
		9.7	20.8	17.4	12.5	19.4	11.1	9.0	33.6
		29.2	38.5	35.2	28.6	53.8	29.1	21.3	
		3.3	7.0	5.8	4.2	6.5	3.7	3.0	
GOOD	12.	18	17	22	19	12	18	25	131
		13.7	13.0	16.8	14.5	9.2	13.7	19.1	30.6
		37.5	21.8	31.0	30.2	23.1	32.7	41.0	
		4.2	4.0	5.1	4.4	2.8	4.2	5.8	
FAIR	13.	4	3	4	4	3	4	4	26
		15.4	11.5	15.4	15.4	11.5	15.4	15.4	6.1
		8.3	3.8	5.6	6.3	5.8	7.3	6.6	
		0.9	0.7	0.9	0.9	0.7	0.9	0.9	
POOR	14.	0	2	0	2	0	1	4	9
		0.0	22.2	0.0	22.2	0.0	11.1	44.4	2.1
		0.0	2.6	0.0	3.2	0.0	1.8	6.6	
		0.0	0.5	0.0	0.5	0.0	0.2	0.9	
DON'T KNOW	88.	2	8	4	7	5	4	10	40
		5.0	20.0	10.0	17.5	12.5	10.0	25.0	9.3
		4.2	10.3	5.6	11.1	9.6	7.3	16.4	
		0.5	1.9	0.9	1.6	1.2	0.9	2.3	
NOT APPL	99.	6	9	0	2	1	4	0	22
		27.3	40.9	0.0	9.1	4.5	18.2	0.0	5.1
		12.5	11.5	0.0	3.2	1.9	7.3	0.0	
		1.4	2.1	0.0	0.5	0.2	0.9	0.0	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

NOTE: Compare this Table with Table M174 regarding Regional Office Staff.

A second form of analysis of this data involved the cross-tabulation of these results with data obtained on the level of satisfaction with T/TA received by these same respondents (see section E1). This cross-tabulation is presented here in Table M48.

Table M48. Cross-Tabulation: Satisfaction vs. Needs Assessment, Planning (n=360)

PROCEFF	TTASATIS: VERY SATISFIED (30.)	SATISFIED (31.)	DISSAT-VERY DIS (32.)	ROW TOTAL
10. EXCELLENT	28	23	4	55
	50.9	41.8	7.3	15.3
	23.5	12.3	7.4	
	7.8	6.4	1.1	
11. VERY GOOD	62	71	9	142
	43.7	50.0	6.3	39.4
	52.1	38.0	16.7	
	17.2	19.7	2.5	
12. GOOD	24	79	26	129
	18.6	61.2	20.2	35.8
	20.2	42.2	48.1	
	6.7	21.9	7.2	
13. FAIR-POOR	5	14	15	34
	14.7	41.2	44.1	9.4
	4.2	7.5	27.8	
	1.4	3.9	4.2	
COLUMN TOTAL	119	187	54	360
	33.1	51.9	15.0	100.0

An assumption made in crossing these two sets of data was that there might well be a relationship between how effective this group of directors, staff, and parents believed their local needs assessment and T/TA planning processes were and how satisfied they were overall with T/TA they had received. What this table shows is that 75.6% of the respondents

who were very satisfied with their overall T/TA answered either "excellent" or "very good" regarding the effectiveness of their needs assessment and T/TA planning processes. This data tends to support the assumption and also leads to the conclusion that the more excellent the needs assessment and T/TA planning processes, the greater tendency there was to be satisfied with T/TA overall.

Another cross-tabulation of this data that seemed appropriate to consider was that with the data on the impact these respondents report that their T/TA had on improving their program. This cross-tabulation is presented here in Table M49.

Table M49. Cross-Tabulation: Impact vs. Needs Assessment, Planning (n-357)

PROGEFF	TTAEFFCT				
COUNT / ROW PCT / COL PCT / TOT PCT	A GREAT IDEAL 20.	QUITE A BIT 21.	SOME 22.	A LITTLE -NONE 23.	ROW TOTAL
10. EXCELLENT	28	14	10	2	54
	51.9	25.9	18.5	3.7	15.1
	23.3	12.5	11.0	5.9	
	7.8	3.9	2.8	0.6	
11. VERY GOOD	57	55	24	6	142
	40.1	38.7	16.9	4.2	39.8
	47.5	49.1	26.4	17.6	
	16.0	15.4	6.7	1.7	
12. GOOD	31	37	44	15	127
	24.4	29.1	34.6	11.8	35.6
	25.8	33.0	48.4	44.1	
	8.7	10.4	12.3	4.2	
13. FAIR-POOR	4	6	13	11	34
	11.8	17.6	38.2	32.4	9.5
	3.3	5.4	14.3	32.4	
	1.1	1.7	3.6	3.1	
COLUMN TOTAL	120	112	91	34	357
	33.6	31.4	25.5	9.5	100.0

The assumption made here again is that there might well be a relationship between how effective the processes of needs assessment and T/TA planning were and the ultimate impact of the T/TA. The fact that, as this table indicates, 77.8% of those respondents who believed their processes were excellent also answered either "a great deal" or "quite a bit" when asked about the impact of T/TA on improving their local program, tends to support the assumption and lead to the conclusion that the better the local needs assessment and T/TA planning processes, the more liklihood for greater impact of T/TA on improving the local program.

These respondents were asked to say how much inprovement they thought was necessary in their processes for assessing T/TA needs and devising T/TA plans. The results are displayed in the next table, Table M50, following this page.

More than seven-tenths of the respondents to this question (72%) felt more than "a little" improvement was required. The greatest concentration of answers was in the "some" category (43.5%), followed by "quite a bit" (15.9%), and "a great deal" (12.6%).

Twelve point six percent represents the percentage of all respondents (428) across seven regions sampled who said "a great deal" of improvement in T/TA needs assessing and planning is needed. Programs sampled in two regions exceeded this "a national norm" somewhat significantly: Region IV Atlanta, 22.5% (16 of 71 respondents) and Region XI IMPD, 23% (14 of 61 respondents)

The question was then asked of all those interviewed "How would you rate the effectiveness of the coordination between the Regional Office and your local program in terms of planning for T/TA at the local level? Would you say it is excellent, very good, good, fair, or poor?" The results of this question are presented in Table M51, following Table M50.

Table M50. Extent of Improvement Needed in Local Program T/TA Needs Assessment and Planning Process (Director, Staff, Parent Respondents, n=428)

NEEDIMPR	REGION: COUNT / ROW PCT / COL PCT / TOT PCT	REGN II 2.	REGN III 3.	REGN IV 4.	REGN V 5.	REGN VI 6.	REGN X 10.	REGN XI 11.	ROW TOTAL
20. A GREAT DEAL		4	6	16	9	3	2	14	54
		7.4	11.1	29.6	16.7	5.6	3.7	25.9	12.6
		8.3	7.7	22.5	14.3	5.8	3.6	23.0	
		0.9	1.4	3.7	2.1	0.7	0.5	3.3	
21. QUITE A BIT		7	11	6	12	7	14	11	68
		10.3	16.2	8.8	17.6	10.3	20.6	16.2	15.9
		14.6	14.1	8.5	19.0	13.5	25.5	18.0	
		1.6	2.6	1.4	2.8	1.6	3.3	2.6	
22. SOME		25	28	37	30	22	21	23	186
		13.4	15.1	19.9	16.1	11.8	11.3	12.4	43.5
		52.1	35.9	52.1	47.6	42.3	38.2	37.7	
		5.8	6.5	8.6	7.0	5.1	4.9	5.4	
23. A LITTLE		3	12	4	6	7	7	4	43
		7.0	27.9	9.3	14.0	16.3	16.3	9.3	10.0
		6.3	15.4	5.6	9.5	13.5	12.7	6.6	
		0.7	2.8	0.9	1.4	1.6	1.6	0.9	
24. NONE		2	6	3	2	3	3	1	20
		10.0	30.0	15.0	10.0	15.0	15.0	5.0	4.7
		4.2	7.7	4.2	3.2	5.8	5.5	1.6	
		0.5	1.4	0.7	0.5	0.7	0.7	0.2	
88. DON'T KNOW		1	7	5	3	7	4	8	35
		2.9	20.0	14.3	8.6	20.0	11.4	22.9	8.2
		2.1	9.0	7.0	4.8	13.5	7.3	13.1	
		0.2	1.6	1.2	0.7	1.6	0.9	1.9	
99. NOT APPL		6	8	0	1	3	4	0	22
		27.3	36.4	0.0	4.6	13.6	18.2	0.0	5.1
		12.5	10.3	0.0	1.6	5.8	7.3	0.0	
		1.4	1.9	0.0	0.2	0.7	0.9	0.0	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

Table M51. Coordination With Regional Office Re T/TA Planning (Director, Staff, Parent Respondents n=428)

COORDEF1	REGION: COUNT / ROW PCT / COL PCT / TOT PCT	REGN II 2.1	REGN III 3.1	REGN IV 4.1	REGN V 5.1	REGN VI 6.1	REGN X 10.1	REGN XI 11.1	ROW TOTAL
10. EXCELLENT		3	8	12	2	5	1	3	34
		8.8	23.5	35.3	5.9	14.7	2.9	8.8	7.9
		6.3	10.3	16.9	3.2	9.6	1.8	4.9	
		0.7	1.9	2.8	0.5	1.2	0.2	0.7	
11. VERY GOOD		6	15	10	14	19	11	6	87
		6.9	17.2	11.4	16.1	21.8	12.6	6.9	20.3
		12.5	19.2	22.5	22.2	36.5	20.0	9.8	
		1.4	3.5	3.7	3.3	4.4	2.6	1.4	
12. GOOD		17	24	27	10	12	11	8	109
		15.6	22.0	24.8	9.2	11.0	10.1	7.3	25.5
		35.4	30.8	38.0	15.9	23.1	20.0	13.1	
		4.0	5.6	6.3	2.3	2.8	2.6	1.9	
13. FAIR		11	6	7	15	4	9	14	66
		16.7	9.1	10.6	22.7	6.1	13.6	21.2	15.4
		22.9	7.7	9.9	23.8	7.7	16.4	23.0	
		2.6	1.4	1.6	3.5	0.9	2.1	3.3	
14. POOR		3	3	2	6	1	4	9	28
		10.7	10.7	7.1	21.4	3.6	14.3	32.1	6.5
		6.3	3.8	2.8	9.5	1.9	7.3	14.8	
		0.7	0.7	0.5	1.4	0.2	0.9	2.1	
88. DON'T KNOW		7	17	6	14	9	10	17	80
		8.8	21.3	7.5	17.5	11.3	12.5	21.3	18.7
		14.6	21.8	8.5	22.2	17.3	18.2	27.9	
		1.6	4.0	1.4	3.3	2.1	2.3	4.0	
99. NOT APPL		1	5	1	2	2	9	4	24
		4.2	20.8	4.2	8.3	8.3	37.5	16.7	5.6
		2.1	6.4	1.4	3.2	3.8	16.4	6.6	
		0.2	1.2	0.2	0.5	0.5	2.1	0.9	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

These findings indicate that 53.7% of all answers obtained across the seven study regions were either excellent, very good, or good; and that 21.9% were fair or poor.

Two regions showed a significantly higher percentage of responses in in the excellent, very good, and good categories: Region IV Atlanta 77.4% vs. the "norm" of 53.7% and Region VI Dallas 69.2% vs. 53.7%. This seems to indicate that respondents in those two particular regions believe there is better coordination with their ROs regarding T/TA planning than is the case in the other five regions.

Region XI, the Indian and Migrant Program Division gave excellent, very good, or good as their response only 27.8% of the time (vs. the "norm" of 53.7%) and fair or poor 37.8% (vs. 21.9%) indicating that more respondents in this region than any other thought the coordination between the Regional Office and local programs was fair or poor. Since the IMPD "regional office" is located in Washington, D.C., and since its "region" is spread across the entire country, it is important to consider the impact of the IMPD findings on this question in the proper context, namely the difference between IMPD's special constituency and other regions' geographic jurisdictions.

By way of getting a further indication of coordination between local programs and ROs, these respondents were asked if they had a chance to have input into the Regional Office T/TA plan. This question also was inserted in order to probe to what extent the local level efforts to assess needs and devise T/TA plans could be utilized at the regional level as well. The results of that data are presented in Table M52, following this page.

The findings from this question are essentially that slightly more than half the respondents felt they had no chance for input into the RO T/TA plan. Unfortunately, the data is not broken out to isolate Director and staff responses from parents. Perhaps if it were, more precise conclusions could be drawn regarding the number of the 30 local programs sampled who have an opportunity for input into the RO T/TA plan.

Table M52. Input of Local Programs into RO T/TA Plan (Directors, Staff, Parent, n=428)

PLANINPT	REGION	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	COUNT								
	ROW PCT								
	COL PCT								
	TOT PCT	2.	3.		5.	6.	10.	11.	
1. YES		19	32	27	24	17	23	11	153
		12.4	20.9	17.6	15.7	11.1	15.0	7.2	35.7
		39.6	41.0	38.0	38.1	32.7	41.8	18.0	
		4.4	7.5	6.3	5.6	4.0	5.4	2.6	
2. NO		26	34	36	33	26	22	45	222
		11.7	15.3	16.2	14.9	11.7	9.9	20.3	51.9
		54.2	43.6	50.7	52.4	50.0	40.0	73.8	
		6.1	7.9	8.4	7.7	6.1	5.1	10.5	
8. DON'T KNOW		2	11	8	5	9	6	5	46
		4.3	23.9	17.4	10.9	19.6	13.0	10.9	10.7
		4.2	14.1	11.3	7.9	17.3	10.9	8.2	
		0.5	2.6	1.9	1.2	2.1	1.4	1.2	
9. NOT APPL		1	1	0	1	0	4	0	7
		14.3	14.3	0.0	14.3	0.0	57.1	0.0	1.6
		2.1	1.3	0.0	1.6	0.0	7.3	0.0	
		0.2	0.2	0.0	0.2	0.0	0.9	0.0	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

Note that Regions III Philadelphia and X Seattle are the two with the largest numbers of respondents who felt they had input into RO T/TA planning. In Philadelphia, 32 of 78 (41%) and in Seattle 23 of 55 (41.8%) answered this question in the affirmative. All respondents in the seven case study regions, considered together, answered this question affirmatively 35.7% of the time.

The respondents were asked a follow-up question, namely, "How would you rate the effectiveness of the coordination between the State Training Office and your program in terms of planning for T/TA at the local level? Would you say it is excellent, very good, good, fair or poor?" The results of this question are given here in Table M53, following this page.

These findings show that 45.8% of all answers obtained across the seven case study regions were either excellent, very good, or good; and that 19.4% were fair or poor.

One region showed an exceptionally higher percentage of excellent, very good, or good responses--III Philadelphia with 71.8% (vs. the "norm" of 45.8% across all seven case study regions). This seems to indicate that respondents interviewed in this region think there is greater coordination with their STO network insofar as T/TA planning is concerned.

Conversely in two regions an exceptionally large percentage of fair or poor answers were reported (vs. the "norm" of 19.4% when all 428 respondents' answers are tabulated): IMPD (32.8%) and Region V Chicago (31.8%). IMPD's percent of excellent, very good, or good responses was only 19.7% (vs. the "norm" discussed above of 45.8%) and Chicago's was 35%.

COUNT / ROW PCT / COL PCT / TOT PCT	REGN II 2.1	REGN III 3.1	REGN IV 4.1	REGN V 5.1	REGN VI 6.1	REGN X 10.1	REGN XI 11.1	ROW TOTAL
COORDEF2								
10. EXCELLENT	2	10	8	3	4	1	0	28
	7.1	35.7	28.6	10.7	14.3	3.6	0.0	6.5
	4.2	12.8	11.3	4.8	7.7	1.8	0.0	
	0.5	2.3	1.9	0.7	0.9	0.2	0.0	
11. VERY GOOD	7	22	10	10	15	19	5	88
	8.0	25.0	11.4	11.4	17.0	21.6	5.7	20.6
	14.6	28.2	14.1	15.9	28.8	34.5	8.2	
	1.6	5.1	2.3	2.3	3.5	4.4	1.2	
12. GOOD	5	24	17	9	9	9	7	80
	6.3	30.0	21.3	11.3	11.3	11.3	8.9	18.7
	10.4	30.8	23.9	14.3	17.3	16.4	11.5	
	1.2	5.6	4.0	2.1	2.1	2.1	1.6	
13. FAIR	5	6	9	11	5	5	12	53
	9.4	11.3	17.0	20.8	9.4	9.4	22.6	12.4
	10.4	7.7	12.7	17.5	9.6	9.1	19.7	
	1.2	1.4	2.1	2.6	1.2	1.2	2.8	
14. POOR	5	1	4	9	1	2	8	30
	16.7	3.3	13.3	30.0	3.3	6.7	26.7	7.0
	10.4	1.3	5.6	14.3	1.9	3.6	13.1	
	1.2	0.2	0.9	2.1	0.2	0.5	1.9	
88. DON'T KNOW	15	13	23	20	17	12	20	120
	12.5	10.8	19.2	16.7	14.2	10.0	16.7	28.0
	31.3	16.7	32.4	31.7	32.7	21.8	32.8	
	3.5	3.0	5.4	4.7	4.0	2.8	4.7	
99. NOT APPL	9	2	0	1	1	7	9	29
	31.0	6.9	0.0	3.4	3.4	24.1	31.0	6.8
	18.8	2.6	0.0	1.6	1.9	12.7	14.8	
	2.1	0.5	0.0	0.2	0.2	1.6	2.1	
COLUMN TOTAL	48	78	71	63	52	55	61	428
	11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

NOTE: Compare this table with Table M51 regarding RO coordination.

KAI interviewers at each of the 30 program sites then asked the Director, staff, and parents if they received a copy of the T/TA plan that RO prepares for and submits to OCD Headquarters each year. The results to this item are presented here in Table M54, following this page.

More than twice as many said no (58.9%) as did yes (25.5%). However, again the data might well be deceiving in that it does not isolate Director and staff responses (presumably they would be more directly the recipients of the RO T/TA plan) from those of the parents.

Region IV Atlanta had a larger number of "yes" responses (35.2%) and a smaller number of "no" responses (49.3%) than any other region, suggesting that more interviewees in that region than any other received a copy of the RO T/TA plan.

In Region X Seattle only 10.9% answered "yes" (vs. the "norm" of 25.5%). Those who responded "yes" when asked if they received a plan from the RO were asked to specify if it was the complete plan or a partial plan or a summary. One hundred and nine answered: 52 (47.7%) said they received the complete plan; eight (7.3%), a partial plan; 36 (33%), a summary; and 13 (11.9%) had other answers.

Table 1154. RO T/TA Plan Available to Local Programs (Director, Staff, Parent Respondents, n=428)

PLANCOPY	REGION	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
		2.	3.	4.	5.	6.	10.	11.	
YES	1.	11	20	25	21	14	6	12	109
		10.1	18.3	22.9	19.3	12.8	5.5	11.0	25.5
		22.9	25.6	35.2	33.3	20.9	10.9	19.7	
		2.6	4.7	5.8	4.9	3.3	1.4	2.8	
NO	2.	31	40	35	36	32	34	44	252
		12.3	15.9	13.9	14.3	12.7	13.5	17.5	58.9
		64.6	51.3	49.3	57.1	61.5	61.8	72.1	
		7.2	9.3	8.2	8.4	7.5	7.9	10.3	
DON'T KNOW	8.	6	16	11	5	6	13	5	62
		9.7	25.8	17.7	8.1	9.7	21.0	8.1	14.5
		12.5	20.5	15.5	7.9	11.5	23.6	8.2	
		1.4	3.7	2.6	1.2	1.4	3.0	1.2	
NOT APPL	9.	0	2	0	1	0	2	0	5
		0.0	40.0	0.0	20.0	0.0	40.0	0.0	1.2
		0.0	2.6	0.0	1.6	0.0	3.6	0.0	
		0.0	0.5	0.0	0.2	0.0	0.5	0.0	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

Lastly, on the subject of needs assessment and T/TA planning, the respondents were asked at which point in the program year they begin their T/TA planning procedures. The responses are given in Table M55.

Table M55. Starting Time for T/TA Planning Procedures (Director, Staff, and Parent Respondents, n=428)

Response	Number (428)	Percentage (100)
On-going	155	36.2
February	14	3.3
March	13	3.0
April	18	4.2
May	17	4.0
Summer	38	8.9
Reception of RO Guidance	8	1.9
Other	39	9.1
Don't Know	102	23.8
Not Applicable	24	3.6

Significant findings here are that:

- 36.2% of the respondents consider their T/TA planning on-going;
- 14.5% start their planning procedures in February, March, April, or May;
- 8.9% begin once they receive the appropriate RO guidance;
- 23.8% reported not knowing when these procedures commence, which is possibly another manifestation of the difficulty encountered when combining parent responses with those of Directors and staff.

Then these same respondents were given a follow-up question, i.e., generally, how much time passes between the beginning of your needs assessment process and the completion of your written T/TA plan? The answers are listed by frequency here in Table M56.

Table M56. Time Involved in Local T/TA Planning Process (Director, Staff, Parent Respondents, n=428)

Time (In Months)	Number of Responses (428)	Percentage of Responses (100)
1	44	10.3
2	51	11.9
3	45	10.5
4	16	3.7
5	10	2.3
6	20	4.7
7	3	0.7
8	3	0.7
9	5	1.2
10	2	0.5
12	17	4.0
Don't Know	153	35.7
Not Applicable	59	13.8

One-third (32.7%) of those answering reported that they complete their T/TA plan within three months of the start of their T/TA needs assessment process. Among IMPD respondents, this figure jumps to 41%.

2. Local Provider Responses

Project Staff interviewed a total of 24 local providers. (See Chapter II for an explanation of the selection process.) Presented here is a discussion of their responses on the subject of needs assessment and T/TA planning. Regional variations in these data will be isolated as appropriate.

Initially, as was true with both the national and regional providers, these local providers were queried about their involvement in needs assessment and T/TA planning activities at the various levels of Project Head Start.

When these providers were asked about their involvement in such processes at the national, regional, state, and local levels, their positive responses were distributed as follows:

Involved at the National Level	0.0%
Involved at the Regional Level	12.5%
Involved at the State Level	25.0%
Involved at the Local Level	58.3%

All providers indicated no involvement at the national level, and then the extent of involvement progressively rises to the high of 58.3% at the local level. The reason for no greater involvement at the local level than 58.3%, is unknown. It may be because local Head Start grantees knew their needs and plan for T/TA and simply hired providers to give the required assistance, or, because local providers didn't possess the expertise for needs assessment and planning, or because some Head Start directors were reluctant to relinquish control to an outsider.

Some regional differences are evident. Among those local providers involved at the state level, one-half were from Region IV (Atlanta). At the local level, while nearly all of the local providers sampled in Regions III (Philadelphia), IV (Atlanta), and XI (IMPD) were involved, most from Region V (Chicago) were not involved (7 out of 9).

A comparison with national and regional providers on this issue of involvement shows some differences. As would be expected, local providers involvement at the national and regional levels was minimal, so we'll turn to state and local level comparisons. Of the local providers sampled, 25.0% were involved at the state level, compared to 17.6% of national and 68.8% of regional providers. The higher percentage of local providers involved than national providers, may be caused in part by health agencies and universities coordinating not only with RTO/STOs (or their equivalent) but also with state-level agencies in their field (e.g., health, social services, education). This question did not distinguish between the two.

At the local level, local provider involvement was 58.3% of all sampled, compared to national (29.4%) and region (77.9%) provider involvement. The closer to "home", the greater the involvement for both local and regional providers. Of course, for the latter group, T/TA needs assessment and planning at the local level is a function normally incorporated in their job requirements, which is not always the case for local providers.

Local providers, like national and regional providers, were asked to indicate which criteria they used to determine their activites. The frequency and rank order of each criterion are listed below in Table M 57. Local Head Start objectives and staff needs both were mentioned most frequently (79.2%), Parent needs ranked second (75.0%), and community needs third (70.8%). These criteria differ in some respects compared to national and regional providers. Table M 58 recapitulates the responses of each type of provider for each criterion.

TABLE M 57. Criteria Utilized to Determine Activities of Local Providers

CRITERIA UTILIZED TO DETERMINE PROVIDER ACTIVITIES	PERCENT OF LOCAL PROVIDERS (n=24)	RANK ORDER OF CRITERIA
National Head Start Objectives	37.5	7
Regional Head Start Objectives	41.7	6
Local Head Start Objectives	79.2	1
Performance Standards	54.2	4
Community Needs	70.8	3
Staff Needs	79.2	1
Volunteer Needs	37.5	7
Parent Needs	75.0	2
Amount of Money Available	45.8	5
T/TA Plan	45.8	5
Part of Grants Application	29.2	8
Contract Requirements	41.7	6
Other Contractors	4.2	10
Other	12.5	9

NOTE: COMPARE THIS TABLE WITH M 6 AND M 28 REGARDING NATIONAL AND REGIONAL PROVIDERS' CRITERIA.

TABLE M 58. Comparison of Criteria Utilized to Determine Activities of National, Regional, and Local Providers

CRITERIA UTILIZED TO DETERMINE PROVIDER ACTIVITIES	NATIONAL PROVIDERS (n=34)		REGIONAL PROVIDERS (n=77)		LOCAL PROVIDERS (n=24)	
	Percent Yes	Rank Order	Percent Yes	Rank Order	Percent Yes	Rank Order
National Head Start Objectives	85.3	3	90.9	4	37.5	7
Regional Head Start Objectives	73.5	5	89.6	5	41.7	6
Local Head Start Objectives	70.6	6	93.5	3	79.2	1
Performance Standards	91.2	1	96.1	1	54.2	4
Community Needs	73.5	5	85.7	6	70.8	3
Staff Needs	88.2	2	94.8	2	79.2	1
Volunteer Needs	50.0	9	72.7	8	37.5	7
Parent Needs	79.4	4	90.9	4	75.0	2
Amount of Money Available	70.6	6	77.9	7	45.8	5
T/TA Plan	58.8	7	85.7	6	45.8	5
Part of Grants Application	47.1	10	59.7	9	29.2	8
Contract Requirements	52.9	8	32.5	10	41.7	6
Other Contractors	23.5	11	26.0	11	4.2	10
Other	8.8	12	11.7	12	12.5	9
Not Applicable	11.9	--	1.3	--	--	--

NOTE: THIS TABLE INCLUDES DATA FROM 3 PREVIOUS TABLES: M 6, M 28, and M 57.

Staff needs were among the most frequently mentioned criteria across all types of providers, but local Head Start objectives, most frequently mentioned by local providers along with staff needs, dropped to third place among regional providers and sixth place among national providers. Parent needs, ranking second among local providers, was mentioned fourth most frequently by national and regional providers. Community needs, named third most often by local providers, fell to the sixth place among regional providers and fifth among national providers. Absent from these most frequently mentioned criteria utilized by local providers are performance standards (54.2% answered "Yes", a drop of more than 15.0% from the next highest percent - community needs) and national and regional Head Start objectives (37.5% and 41.7% respectively). It is obvious that among our sample, local providers must try to be highly responsive to the requirements of the local program, through its objectives and staff and parent needs. To what extent local Head Start objectives incorporate regional and national objectives is not known from our data.

When local providers were asked to name the top three criteria, in order of importance, for determining their T/TA activities, the frequencies for each criterion mentioned (See Table M59) emerged. Because of the small number of local providers interviewed, the percentages for several criteria are the same. When this occurs, only those criteria with distinctly different percentages will be discussed. Among the first-ranked criteria, children needs (29.2%) and staff needs (25.0%) were most frequently mentioned. Among second-ranked criteria, staff needs (29.2%0, local Head Start objectives (12.5%) and parents needs (12.5%) were named most often. Among third-ranked criteria, staff needs and parent needs (both 16.7%) ranked highest. When the percentages across each of the ranked criteria are aggregated, staff needs is far and away the most mentioned criterion (70.9%), followed by children needs (41.7%), and then parent needs (29.2%) and local Head Start objectives (29.1%).

TABLE M 59. Top-Ranked Criteria for Determining T/TA Activities of Local Providers (n=24)

CRITERIA NAMED FOR DETERMINING PROVIDER ACTIVITIES	PERCENT OF LOCAL PROVIDER RESPONSES			
	First Ranked	Second Ranked	Third Ranked	Aggregate
National Head Start Objectives	4.2%/1	4.2%/4	4.2%/3	12.6%/6
Regional Head Start Objectives	--	--	--	--
Local Head Start Objectives	8.3%/3	12.5%/2	8.3%/2	29.1$/3
Performance Standards	8.3%/3	4.2%/4	4.2%/3	16.7%/5
Community Needs	4.2%/4	8.3%/3	8.3%/2	20.8%/4
Staff Needs	25.0%/2	29.2%/1	16.7%/1	70.9%/1
Volunteer Needs	--	4.2%/4	--	4.2%/7
Parent Needs	--	12.5%/2	16.7%/1	29.2%/3
Children Needs	29.2%/1	4.2%/4	8.3%/2	41.7%/2
Amount of Money Available	--	4.2%/4	8.3%/2	12.5%/6
T/TA Plan	--	4.2%/4	--	4.2%/7
Part of Grants Application	--	--	--	--
Contract Requirements	4.2%/4	--	--	4.2%/7
Other Contractors	--	--	--	--
Program Needs Assessment and Evaluation	8.3%/3	4.2%/4	4.2%/3	16.7%/5
Provider Self-Assessment and Evaluation	--	--	--	--
Other	4.2%/4	4.2%/4	4.2%/3	12.6%/6
No Response or Not Applicable	4.2%	4.2%	16.7%	--

NOTE: COMPARE THIS TABLE WITH M 7 REGARDING NATIONAL PROVIDERS AND M 29 REGARDING REGIONAL PROVIDERS.

It can be seen that when these providers ranked the criteria, the top 3 in rankings - staff needs, children needs, local objectives - were identical to responses that were given when they were asked to indicate whether or not they used certain criteria (Table M 57).

No regional variations among the local providers in these data are notable.

Comparing these results of the aggregated percentages with national and regional providers reveals striking differences among the respondents. Staff needs rank fourth among national (Table M 7) and regional providers (Table M 29). Children needs rank eleventh among national providers (Table M 7) and thirteenth among regional providers (Table M 29). Parent needs rank eighth and ninth among national (Table M 7) and regional (Table M 29) providers, and local Head Start objectives sixth and third respectively (Tables M 7, and M 29).

As far as constants among these criteria employed by T/TA providers at all three levels - national, regional, and local, this much can be said:

- o Staff needs were mentioned frequently on all 3 levels.
- o Performance standards were mentioned consistently on the national and regional levels (but not on the local)
- o Local objectives were mentioned regularly on the regional and local levels (but not on the national)
- o Regional objectives and national objectives were mentioned less frequently than the above, but still regularly - on the regional and national levels (but not on the local)
- o Parent's needs, children's needs, and community needs were mentioned regularly, but only on the local level.

One other comparison must be made, and that is the top criteria used by local programs against those used by local level providers for needs assessment and T/TA planning.

Recall from Tables M 36, M 37, and M 38, that five criteria stood out consistently as dominant ones employed by the directors, staff and parents interviewed:

- Staff Needs
- Parent Needs
- Performance Standards
- Community Needs
- Local Objectives

These are almost exactly the same criteria mentioned most regularly by the local providers (See Tables M 57 and M 59). The only difference is the criterion of children's needs, which was mentioned quite often by these providers. Accordingly, it seems fair to say that local program personnel and T/TA providers seem very much synchronized on the matter of which criteria to utilize for assessing needs and devising T/TA plans.

Local providers were then asked which resources from a pre-set list they utilized to assess T/TA needs and devise the T/TA plan. The percentages of positive responses are presented below in Table M 60.

The resources most frequently utilized was program staff meeting (66.7%). Following that, program staff evaluation forms and local provider staff meetings were most often named (each 45.8%). Formal needs assessment tools and provider staff evaluation forms fell in the fourth decile (37.5 and 33.3% respectively). All other resources dropped to 20.8% and below in use by local providers. Reliance was greatest on local program resources in the form of meetings and evaluations. Least reliance was placed on National offices staff, materials and guidance, and other provider reports. It appears that local providers, in concert with local program personnel, generated their own T/TA needs assessment and planning and that outside resources, such as regional providers, National and Regional office staff, and materials were not primary.

Table M 60. Resources Utilized by Local Providers for Assessing T/TA Needs and Devising T/TA Plan (n=24)

TYPE OF RESOURCE	PERCENT OF LOCAL PROVIDERS UTILIZING RESOURCES
Formal needs assessment tools	37.5%
Program Staff evaluation forms	45.8%
Program Staff meeting	66.7%
Provider reports (RTO/STO/STATO/OICS)	20.8%
Other provider reports	8.3%
Staff evaluation forms	33.3%
Staff meetings	34.8%
National office materials/guidance	8.3%
National office staff (e.g., CDTA, PD&I)	8.3%
Regional office materials/guidance	20.8%
Regional office staff (e.g., Community Rep)	16.7%
Other	12.5%
Not Applicable	12.5%

NOTE: COMPARE THIS TABLE WITH M 8 (NATIONAL PROVIDERS) AND TABLE M 30 (REGIONAL PROVIDERS)

No regional variations were notable.

Comparing local provider responses with those of regional and national shows that, overall, local providers evidenced a lower range of positive responses than either of the other provider groups. (See Table M 61) However, on an individual resource item basis, they compared favorably with regional providers and surpassed national providers in utilizing program staff meetings. That favorability with regional providers dimishes in regard to program staff evaluation forms. For whatever reasons - nonavailability of local program staff and materials, nonavailability or inappropriateness of formalized tools and evaluations, inexpertise of local provider staff, nature of the task to be accomplished, etc. - the resources utilized by local providers tend to be of a more informal, interpersonal nature. This observation should not be construed as a criticism. The fact that such is the situation at the local level may in fact be most appropriate for accomplishing the tasks of T/TA for which local providers were hired.

These local providers were then asked if they prepared a written T/TA plan or work statement. The range of responses was:

Yes	97.5%
No	8.3%
Not applicable	4.2%

The percentage of "Yes" responses is close to that of regional providers (92.2%) and higher than that of national providers (64.7%).

Those local providers who responded "Yes" were then requested to specify to whom and how often they submitted their plans. The following Table (M 62) presents this data.

TABLE M 61. Comparison of Resources Utilized by National, Regional, and Local Providers for Assessing T/TA Needs and Devising T/TA Plan

TYPE OF RESOURCE	PERCENT OF PROVIDERS UTILIZING RESOURCE		
	National (n=34)	Regional (n=77)	Local (n=24)
Formal needs assesment tools	55.9	79.2	37.5
Program staff evaluation forms	29.4	72.7	45.8
Program staff meeting	41.2	70.1	66.7
Provider reports (RTO/STO/STSTO/OICS)	41.2	72.7	20.8
Other provider reports	11.8	46.8	8.3
Staff evaluation forms	32.4	70.1	33.3
Staff meetings	38.2	72.7	45.8
National office materials/ guidance	67.6	80.5	8.3
National office staff (e.g., CDTA, PD&I)	50.0	37.7	8.3
Regional office materials/ guidance	47.1	85.7	20.8
Regional office staff (e.g., Community Rep)	61.8	76.6	16.7
Other	17.6	32.5	12.5
Don't Know	--	--	--
Not Applicable	11.8	1.3	12.5

NOTE: THIS TABLE INCORPORATES DATA DISPLAYED PREVIOUSLY IN TABLES M 8, M 30, AND M 60.

Table M 62. Percent of Local Providers Submitting Written T/TA Work Plan to Organization or Agency and Frequency of Submission (n=24)

RECIPIENT OF T/TA PLAN	PERCENT OF LOCAL PROVIDERS SUBMITTING PLAN	FREQUENCY OF SUBMISSION				
		Monthly	Quarterly	Semi-Annually	Annually	Other
Employer	45:8	8.3	--	8.3	16.7	12.5
Policy Advisory Board	4.2	4.2	--	--	--	--
Grantee Board	8.3	--	--	--	8.3	--
State T/TA Grantee	8.3	--	--	--	8.3	--
Regional Office	4.2	--	--	--	4.2	--
National Office	4.2	4.2	--	--	--	--
Part of Grants Application	0.0	--	--	--	--	--
Part of Contract Requirements	0.0	--	--	--	--	--
Other	16.7	4.2	--	--	8.3	4.2

NOTE: COMPARE THIS TABLE WITH M 9 (NATIONAL PROVIDERS) AND M 32 (REGIONAL PROVIDERS)

Note: All percentages are based on the total number of respondents. Because this question was designed to permit multiple responses for the recipient part only, no percent equals 87.5%, the number of respondents answering "Yes" to the preceding question. Respondents were allowed to give only one frequency for each recipient, so each frequency row percents total the recipient percent listed in the second column.

Most respondents indicated submitting T/TA plans to their employer (45.8%). In a few instances this employer was the local Head Start grantee, but in most cases the referent was the university, community health agency, tribal agency, or private organization that had received the grant or contract to provide T/TA services. The category next most frequently mentioned as a recipient was other (16.7%). This category included a variety of responses: "director" of T/TA services (as distinct from T/TA grantee or contractor); "Head Start director"; "teachers and nurses"; and "staff and parents". All other categories of recipients fall in the lowest decile ranging from 8.3 to 4.2%, with the exception of part of grants application and part of contract requirements, each registering 0.0% responses.

The frequency of T/TA plan submission to each recipient generally follows the pattern of being required only once, either on a monthly basis or an annual basis. The only exceptions to this pattern are found with frequency of submission to employer and to "others". The frequency distribution for employer is monthly (8.3%), semi-annually (8.3%), annually (16.7%), and other (12.5%). In the latter frequency, time frames such as "weekly", "as requested", and "once" were mentioned. The second exception to the pattern is frequency to other agency or organization, which evidences this distribution: monthly (4.2%); annually (8.3%); and other (4.2%).

Then, as with the national and regional providers, these respondents were asked "how effective is the process you use to assess the T/TA needs and devise your T/TA plan?" Table M 63 presents their responses. Of those who were involved in T/TA needs assessment and planning, 70.8% gave positive (i.e., excellent, very good, good) ratings. Regional variations occur among these providers. Respondents, rating the effectiveness of their processes highly (excellent, very good) totalled 37.5%. Of the remaining percent (41.6%) who rated their effectiveness (good and fair), most were located in Regions IV and V.

TABLE M 63. Effectiveness of Local Provider T/TA Needs Assessment and Planning Process (n=24)

RESPONSES	PERCENT
Excellent	12.5%
Very Good	25.0
Good	33.3
Fair	8.3
Poor	---
Don't Know	4.2
Not Applicable	16.7

NOTE: COMPARE THIS TABLE WITH M 10 (NATIONAL PROVIDERS) AND M 33 (REGIONAL PROVIDERS).

Although this percentage is lower than both regional (93.6%) and national (79.5%) providers, it should not be construed as meaning that as a body, these local providers are less effective. The large percent of respondents answering "not applicable" (16.7%) indicates that they are not involved in these processes. Further, the total number of local providers sampled, 24, is small. Like the other providers, no one used the rating "poor". (For a tabular recapitulation of all provider responses to this question, see Table M64.)

TABLE M 64. Comparison of Ratings of Effectiveness of T/TA Needs Assessment and Planning Process by National, Regional, and Local Providers

RESPONSE CATEGORY	TYPE AND PERCENT OF PROVIDER RESPONDENTS		
	National (n = 34)	Regional (n = 77)	Local (n = 24)
Excellent	20.6	20.8	12.5
Very Good	32.4	48.1	25.0
Good	26.5	24.7	33.3
Fair	11.8	3.9	8.3
Don't Know	--	--	4.2
Not Applicable	8.8	2.6	16.7
TOTAL	100.1*	100.0	100.0

NOTE: THIS TABLE INCORPORATES DATA DISPLAYED PREVIOUSLY IN TABLES M 10, M 33, AND M 63.

*Caused by rounding.

Essentially, this table highlights the finding that regional providers, as mentioned above, rate the effectiveness of their needs assessment and T/TA planning processes more highly (93.6%) than do either the national (79.5%) or local (70.8%) providers.

One other comparison should be made - the ratings on effectiveness of the local providers vs. those of the directors, staff, and parents from the thirty local programs sampled. Recall that 77.3 percent of these latter respondents (See Table M 47) reported the effectiveness of their processes at the local program as being either excellent, very good, or good. This figure of 77.3 percent should be considered against the 70.8 percent response rate of the local providers. What is of importance here is that the local program people seem more satisfied than the local providers with these needs assessment and T/TA planning processes.

Also noteworthy is that here on the local level, for the first time, we have more satisfaction with these processes by the Head Start people instead of the providers. Providers at both the national (especially) and regional levels seemed to be more satisfied than the OCD officials with these processes.

The local providers were queried as to how much improvement they thought was necessary in these processes. Their answers are displayed here in Table M 65..

TABLE M 65. Extent of Improvement Needed in Local Providers' T/TA Needs Assessment and Planning Processes (n=24)

RESPONSES	PERCENT
A Great Deal	8.3%
Quite a Bit	29.2%
Some	33.3%
A Little	4.2%
None	8.3%
Don't Know	4.2%
Not Applicable	12.5%

NOTE: COMPARE THIS TABLE WITH M 11 (NATIONAL PROVIDERS) AND M 34 (REGIONAL PROVIDERS)

It can be seen that 37.5% think rather extensive improvements (i.e., a great deal or quite a bit) are needed; 33.3%, only "some"; and 12.5% a little or none. All local providers who answered the "a great deal or quite a bit" of improvement was needed (37.5%), were from either Region IV (Atlanta), or Region V (Chicago). This was the only notable variation in this data in terms of regions.

Comparing these data to those obtained from the national and regional providers (see Tables M 11 and M 34) shows some differences. A much larger percentage of the local providers interviewed (37.5%) think extensive improvements (i.e., "a great deal or quite a bit") are needed than of the regional (14.3%) or national (17.7%) providers. It is not known at this time whether this difference can be explained, e.g., as a result of lack of money, program expertise, or provider expertise, to do a good job, at the local level.

For the reader's convenient reference a table is presented here summarizing the answers of all T/TA providers interviewed on this subject of improvements needed in the processes utilized to assess needs and devise T/TA plans.

TABLE M 65. Comparison of Responses by All Providers on the Extent of Improvement Needed in Needs Assessment and T/TA Planning.

RESPONSE CATEGORY	TYPE AND PERCENT OF PROVIDER RESPONDENTS		
	National (n=34)	Regional (n=77)	Local (n=24)
A Great Deal	5.9	6.5	8.3
Quite a Bit	11.8	7.8	29.2
Some	47.1	62.3	33.3
A Little	14.7	18.2	4.2
None	8.8	2.6	8.3
Don't Know	--	--	4.2
Not Applicable	8.8	2.6	12.5
No Response	2.9	--	--
TOTAL	100.0	100.0	100.0

One other comparison needs to be made here, and that is the comments made by the local providers on improvement needed against those of the local program directors, staff and parents. Recall (from Table M 50) that 7/10ths (72.0%) of the respondents in that category felt that more than "a little" improvement was needed. This matches the local providers comparable percentage of 70.8% and tends to indicate that the local program people feel about the same need for improvement as do the local providers. This also tends to show, relatively, a synchronization of perceptions by both local program people and providers on this subject that does not exist to such an extent on either the regional or national levels. The word "relatively" was used intentionally, so as to avoid suggesting that these processes are any better at the local level than at the other levels just because both parties, i.e., the program people and the providers, view them so identically.

As with national and local providers, local providers rated the effectiveness of the coordination (in terms of planning for T/TA at the local level) between their organization and each of these offices: the National Office; the Regional Office; the State Training Office (or its equivalent); and the Local Grantee. Previously discussed was the fact that to make each rating, local providers had to be involved in the T/TA needs assessment and planning process at that particular level. For reference, the percent involved at each of those levels is presented below:

LEVEL OF INVOLVEMENT BY LOCAL PROVIDERS IN T/TA NEEDS ASSESSMENT AND PLANNING PROCESS	PERCENT OF LOCAL PROVIDERS INVOLVED
National	0.0
Regional	12.5
State	25.0
Local	58.3

The following table (m 66) shows the distribution of ratings by local providers. The ratings were almost uniformly positive (excellent, very good, good) across each level. Only in rating coordination effectiveness with local grantee was "excellent" used, however. It appears that most providers involved with the local grantee in planning T/TA enjoyed a positive relationship with high coordination or effectiveness. This fact again points up the apparent synchronization existing between local programs and providers sampled that was evidenced in the previous discussion about effectiveness and extent of improvement needed in needs assessment and T/TA planning processes.

TABLE M 66. Percent of Local Providers Rating Effectiveness of Coordination in T/TA Planning at the Local Level Between their Organization and the National Office, Regional Office, State Training Office, and Local Grantee

RATING	PERCENT OF LOCAL PROVIDERS RATING EFFECTIVENESS OF COORDINATION WITH EACH OFFICE			
	National Office	Regional Office	State Training Office	Local Office
Excellent	--	--	--	28.6%
Very Good	--	66.6%	33.3%	35.7%
Good	--	33.3%	50.0%	28.6%
Fair	--	--	[illegible].7%	7.1%
Poor	--	--	--	--
n =	--	3/24	6/24	14/24
Not Reported	24	21	18	10

NOTE: COMPARE THIS TABLE WITH M 12 (NATIONAL PROVIDERS) AND M 35 (REGIONAL PROVIDERS)

Regional variations among local providers rating coordination effectiveness at the local level do exist. Of the 7 out of 9 local providers interviewed in Region IV who rated coordination effectiveness, 6, or 85.7% gave highly positive responses (excellent and very good).

To recapitulate the positive responses, not only for local providers, but also for regional and national providers, Table M 67, on the following page, has been constructed.

TABLE M 67. Comparison of All Provider Responses on Effectiveness of Coordination between their Organization and OCD/H.S.

TYPE OF PROVIDER	PERCENT OF POSITIVE RESPONSES (EXCELLENT, VERY GOOD, GOOD) OF THOSE PROVIDERS RATING COORDINATION EFFECTIVENESS WITH EACH OFFICE OR AGENCY			
	National Office	Regional Office	State Training Office	Local Office
National Providers	80.0%	71.4%	40.0%	55.5%
Regional Providers	60.0%	91.1%	73.1%	89.8%
Local Providers	--	100.0%	83.2%	92.9%

NOTE: THIS TABLE INCORPORATE DATA PREVIOUSLY DISPLAYED IN TABLES M 12, M 35, and M 66.

As a general finding, it appears that each category of provider experiences a higher level of positive coordination effectiveness with his or her immediate employer or critical client than with other offices. That is, most national providers rated coordination effectiveness for both the national and regional offices positively, and with both these offices it is important that this condition exists, in order to maintain the relationship and accomplish the tasks needed. Similarly, nearly all regional providers rated coordination effectiveness with the regional office and the local grantee positively, and nearly all local providers did the same for the regional office and local grantee. It is realistic to assume that each provider group and the particular office dispensing the T/TA money or receiving the bulk of T/TA services have a vested interest in maintaining good coordination with each other, to insure that the job is done well and that continuance of the money for contracts is not jeopardized.

Summation of M3 Findings: Needs Assessment and T/TA Planning

The topical question addressed in this section was, "are appropriate and effective processes followed to assess needs and develop T/TA plans accordingly?" A basic assumption, of course, is that the most effective and efficient T/TA activities are based solidly on a thorough assessment and analysis of T/TA needs.

Information gathered from National Office Head Start staff strongly indicates that the central office sees its responsiblities, in the needs assessment process, limited to the design of formats for needs assessment data gathering and to tabulate centrally data as it is gathered by the local and regional levels. Central office staff perceived the primary responsibility for T/TA needs assessment to rest with the local level; secondary duties involving a "quality control" function were seen to be the responsibility of the regional office. Furthermore, central office staff perceived virtually no meaningful comprehensive and integrated planning processes at either the national, regional or local levels levels which are followed to incorporate the results of the needs assessment into the T/TA delivery. Finally, central office staff saw the effectiveness of the total needs assessment process at each level as only "Fair" on a scale of Excellent/Very Good/Good/Fair/Poor.

National level T/TA providers, likewise, were questioned on dimensions relevant to their level of involvement in the needs assessment and T/TA planning activities. Although providers' level of involvement appeared to be greater than that of headquarters staff, the providers primary criteria to determine what their activities would be tended to be related to Head Start performance standards and national objectives (See Tables M6 and M7). National providers generally perceived their needs assessment and planning processes as rather effective; obviously, this perception stands in marked contrast with that of central office staff. In general, national providers saw the degree of coordination between themselves, the National Office, the regional office, the State office and the local grantee as quite favorable.

Regional office respondents, in contrast with National office self-perceptions, saw themselves as having a highly significant role in the needs

assessment process at both the regional and local levels; in declaring the participants in this process regional office staff saw themselves in a primary role (See Table M14). Likewise, regional office staff generally (81%) perceived the effectiveness of the needs assessment process in the excellent/very good/good range (See Table M17).

Regional office staff recognized two primary bases for setting priorities at the regional and local levels among identified needs: the National Performance Standards and the National Objectives (See Table M18). Regional staff also regarded the regional T/TA planning process to be of significant effectiveness (See Table m19).

Regional office staff generally perceived the degree of effective coordination between the regional office and local programs to be very good (See Table M20); in contrast, regional office personnel saw the degree of coordination between regional office and the National office generally to be "Fair" to "Poor". When asked how coordination efforts between regional and national offices could be improved, regional office people suggested changes in National office organization, planning, management, timing, service delivery and attitudes. As seen by regional staff, improvement in regional-local office coordination would require regional office reorganization with increased manpower; regional staff also revealed that significant numbers of local programs did not receive copies of the regional T/TA plan.

Information on the needs assessment and T/TA planning process was also sought from representatives of the RTO/STO/STATO/OICS network. Some 93% of respondents in this group felt there was a discernable need for improvement in this process (See Table M23). The suggestions for improvement most frequently related to staff, i.e., upgrading staff expertise, retraining staff for longer periods, adding more staff, etc. Virtually all RTO/STO (etc.) prepare a T/TA plan and submit that plan to the regional office. However, over half of these personnel cited a need for better communication with the regional office. For the most part the RTO/STO do seem to have a rather clear set of objectives from the regional office regarding specified expectations for job performance (See Table M27).

A second group of regional providers across seven case study regions was also queried on needs assessment. In contrast to National providers, this group of regional providers had their greatest level of involvement in the needs assessment/planning process at the local, state and regional level. The criteria used to determine the T/TA activities of this group of regional providers were very similar, however, to those employed by National providers (See Table M28 and M29); there is, however, an expected tendency to place greater emphasis on regional and local objectives. Virtually all of this group of regional providers prepared a written T/TA plan (see Table M32). Likewise, this group generally (93.6%) perceived a positive level of effectiveness of their T/TA needs assessment/planning activities (see Table M33). Over 75%, however, do feel a need for further improvement in this process (see Table M34).

Further responses on the needs assessment and planning process were sought from local level sources of H.S. directors and staff, and parents. Without doubt this group placed heavy emphasis on parent needs, staff needs, local objectives, and community needs in establishing their criteria for assessing local T/TA needs (see Tables M36 and M37). The resources utilized at the local level in assessing needs and devising T/TA plans were primarily staff meetings and staff evaluation forms (see Table M39). Of this group of interviewees 77.3% rated the effectiveness of the needs assessment/planning process as Excellent, Very Good, or Good (see Table M47); only 8.2% rated the effectiveness as "Fair" or "Poor." Nevertheless, some 72% of the interviewees felt that more than "a little" improvement was required in the total process (see Table M50).

Some 53.7% of local level personnel thought that the effectiveness of coordination between local and regional offices was Excellent; Very Good, or Good; 21.9% saw such coordination as Fair or Poor. (see Table M51) There is some indication that over 50% of the respondents felt they had no opportunity for input in the development of the regional T/TA plan. Over one-third of the respondents reported that their T/TA planning procedures were on-going while another 23.8% reported that they did not know as to the onset of the planning process; only 1.9% of the respondents reported that they waited

to begin their T/TA planning process until after the receipt of regional office guidance. Approximately one-third of the respondents reported that they had completed their written T/TA plan within three months after beginning the planning process (see Table M56).

In addition to local directors, staff, and parents, inquiry was also made on the needs assessment and planning process of a number of local providers. This group reported involvement in such processes at the various levels as follows:

National level:	1.1%
Regional Level	12.5%
State Level	25.0%
Local Level	58.3%

Local providers reported the criteria used to determine their T/TA activities to be primarily local Head Start objectives, staff needs, parent needs and community needs (see Table M57 and M59). A large majority (97.5%) of local providers do prepare a written T/TA plan and submit the plan to various offices for approval. Over 70% of this group regard the effectiveness of their needs assessment/planning process to be Excellent/Very Good/or Good (see Table M63). Nevertheless, over 70% saw the need for more than "a little" improvement in the process (see Table M65). Finally, local providers generally feel very positive about the effectiveness of coordination between themselves and local, state, and regional offices (see Table M66).

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

Section H4: Is an appropriate and effective T/TA provider selection/ assignment process in place?

KAI staff believed that another major indicator of the way in which T/TA is managed was the manner and related aspects of selection of providers of training and technical assistance. In this section the topic of provider selection will be addressed at the national, regional, and local levels.

a. National Level Responses

National level responses on this topic of provider selection, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of OCD HQ officials and then from that of national T/TA providers.

1.) OCD Headquarters Responses

Before being asked questions directly on the subject of provider selection, the 24 OCD Headquarters officials interviewed were first asked, by way of giving background information on overall funding levels and budget constraints that impinge on the allocating of monies for T/TA, to explain the bases on which T/TA money (and overall

program money) is alloted to each region. The results of this questioning showed that central office interviewees as a group clearly do not perceive any basis or pattern through which the Regions are allocated T/TA monies. A few respondents speculated that funding patterns were set several years ago--but the basis for the pattern is not specified--and that the central office has continued to allocate T/TA monies according to that historical precedent. A very small number of respondents indicated that such T/TA allocation might be based upon the comparative numbers of children served by the various regions; however, no interviewee could/would articulate the rationale linking the "number of children served" with "T/TA needs" for any Region.

Likewise central office staff are unaware of specific funding patterns for the Regions in regard to total program budget allocations. There is some consensus that the rationale for allocation of general budget funds is based upon the historically determined precedent of number of children served in the region; however, specific dollar allocations are not generally known among staff.

Some of these HQ respondents also mentioned that special programs or operations at the local or regional level may result in allocated monies beyond basic budget provisions based upon the number of children served. For example, a particularly innovative health component may be funded with monies on top of the number-of-children-served formula.

Directly on the subject of provider selection, the central office staff revealed considerable consensus that the criteria for selecting T/TA providers at all three levels (national, regional, and local) was the competitive ability of the provider to meet the specific requirements of the various contract RFPs. Thoughts were expressed that there may be opportunity for even more extensive competitive processes particularly at the local and regional levels.

OCD Headquarters staff were asked to comment on the effectiveness of the process of selection of national T/TA providers. With few exceptions (most of which were identified with limited experience in this area), central office staff perceived the current competitive process in national T/TA selection to be quite effective. On a rating scale consisting of Excellent/Very Good/Good/Fair/Poor, over 80% of the interviewees who answered this question regarded the effectiveness of the competitive process to be in the "Excellent," "Very Good," and "Good" categories.

Table M68. Effectiveness of Process for Selection of National T/TA Providers

Responses	Frequency
Excellent	5
Very Good	5
Good	2
Fair	2
Poor	1

(n=24, not all of whom responded)

National Office personnel did not appear to have sufficient data upon which to rate this process for regional and local levels.

The central office staff were requested to suggest improvements which could be made in the process of selection of providers. Some of their noteworthy recommendations were:

1. More coordination between projects which are funded discretely and are separate procedurally. This kind of communication and cooperation would result in the better delivery of the separate T/TA efforts and the avoidance of overlapping or redundancy in methods and content.

2. The selected provider for any T/TA activity should clearly demonstrate a comprehensive knowledge of Head Start policy, procedures, history, publications, etc. This capability is regarded to be essential in avoiding the provision of T/TA service which operates in isolation and without continuity of effort.

3. Based upon the assumption that the local level is the likeliest to be most familiar with its own needs, consideration ought to be given to increasing budgetary appropriations to the local level so that it may determine and provide more adequately for its T/TA needs.

4. Increased emphasis should be placed on further competitive processes for selection of T/TA providers at the local level.

2.) National T/TA Providers Responses

Related to the issue of provider selection is how each particular provider is chosen for the particular job to be performed. We did not ask providers on what basis their organization was selected to receive the T/TA contract or grant, but we did ask them about the criteria that determined his/her assignment to a regional office or a grantee, whichever case was appropriate. National provider answers are given here:

Table M69. Criteria Determining Assignment of National Providers (n=34)

Response	Percent of National Providers Answering "Yes"
In geographic area I serve	41.2
Need my particular expertise	76.5
Familiarity with geographic area	26.5
Familiarity with type of program	47.1
Other	32.4
Not applicable	2.9

Most respondents were placed where they were because their particular expertise was needed (76.5%). The types of responses given for other (32.4%) included requested by Regional or National Office, program or Regional Office needs, and personal choice or special interest in particular group of children.

b. Regional Level Responses

Regional level responses on this topic, provider selection, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1.) Regional Office Responses

These responses are further divided into two parts: an aggregated analysis of responses from all eleven regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter on findings.

a) Aggregated analysis of all eleven regions

(See Chapter II for an explanation of the selection process for selection of interviewees in the Regional Offices)

All 64 regional respondents were asked about the current practices and level of effectiveness of selection of regionally-funded providers and (where appropriate) RTO/STOs--as well as about possible ways to improve these practices. What follows here is a discussion of the variety of responses of Regional Office interviewees aggregated together.

Generally Requests for Proposals (RFPs) were consistently listed as the mechanism for announcing the region's T/TA needs for contractual help. Once the RFPs have been responded to, various criteria are employed by the regions in weighing the relative merits of contractors' proposals. Among them are:

* experience as trainers or providers of technical assistance
* knowledge of the Head Start philosophy, operations
* sensitivity to cultural and economic realities and differences
* commitment to getting the job done efficiently

In many cases these decisions about the relative merits of varous contractors are arrived at jointly, e.g., through the collective efforts of a T/TA committee. The two single individuals most regularly involved, according to all respondents, are the OCD Director (RPD) and the Program Review and Resource Specialist (PR&R).

This information was gleaned when KAI project staff asked Regional office respondents who the key participants were in the process employed to select T/TA providers in a given region. All the answers received to that question are displayed here in Table M70:

Table M70. Regional Office Participants in Provider Selection

RESPONSES	FREQUENCY
OCD Director (RPD) alone	2
OCD Director (RPD) jointly	9
with ARD	1
with PR&R	6
with others	2
PR&R Specialist alone	1
PR&R Specialist jointly	6
with OCD Director	6
T/TA Committee	5

(n=64, not all of whom were asked to respond)

Regional respondents were asked to rate the effectiveness of their processes for selecting providers of T/TA. Of the 24 that responded, the answers clustered this way on a scale of Excellent/Very Good/Good/Fair/Poor:

Table M71. Effectiveness of Process for Selection of Regional T/TA Providers

RESPONSES	FREQUENCIES	PERCENTAGES
Excellent	4	16%
Very Good	12	50%
Good	5	21%
Fair	2	8%
Poor	1	4%
	24	100%

Note: Compare this table with M68 regarding National Providers.

All told 88% responded either "Excellent," "Very Good," or "Good," whereas only 12% answered "Fair" or "Poor."

On the subject of improvements in the process of regional provider selection, regional respondents were asked whether or not they believed improvements were necessary. Of the dozen people asked this question, nine said "Yes" and three said "No." While the "n" here is quite small, the ratio is noteworthy, that is, 3 respondents out of every four believe some further improvement is needed.

Many respondents offered specific suggestions on how to improve the process. Among these were the following:

- design a more consistant system
- allow for additional, more flexible systems
- develop better mechanisms for assessing capabilities of the provider
- achieve a situation which insures continuity of providers as well as high quality of T/TA.

None of these obviously represents entirely new insights into the process of selecting providers; each instead speaks to qualitative improvement of the essential system currently in place. This interpretation of the various suggestions for improvement helps also to reconcile the fact that any recommendations were made at all, with the high percentage (88%) who previously responded that they believed present processes for selecting providers were "Excelent," "Very Good," or "Good."

Regional respondents were asked how RTO or STO (or STATO or OICS) grantees are selected. The aggregation of these answers show a wide variety; ranging between these two extremes:

- open competition annually
- automatic renewal of contracts (grants)

With such extremes it is difficult to say any pattern of selection dominates all or even most of the eleven regions.

One facet of this selection process that did yield interesting and rather consistent results from the respondents was the matter of who the decision-makers are in picking RTO/STOs. Some regions apparently form ad hoc committees to make these decisions. A typical committee spoken of included representation from Head Start Directors, parents, and the Regional Office.

Most regions seem to involve the PR&R Specialist and/or the OCD Director (RPD) in this process. In fact, no other specific official at the regional level was mentioned as being involved.

Once the grantee to serve as RTO/STO has been selected, the matter of selecting staff needs to be considered. Again, over all ten regions (exclusive of Region I), results indicate rather regular collaboration between the regional office and the grantee (e.g., university) in the choosing of staff. In some cases it is the region itself that takes the lead; in others the grantee does; and in still others the region allows the grantee to make selections but retains the right of veto. No matter which approach is followed, generally there is cooperation between both parties, i.e., the Regional Office and the grantee.

Of those being interviewed in the regions eleven gave an opinion on how effective they thought the selection process was for STO/RTO/STATO/OICs grantees. On a scale of Excellent/Very Good/Good/Fair/Poor, the answers were distributed thusly:

Table M72. Effectiveness of Process for Selection of RTO/STOs

RESPONSES	FREQUENCY
Excellent	2
Very Good	3
Good	4
Fair	1
Poor	1
Don't Know	1
Total	12

(n=64, not all of whom were asked to respond)

Note: Compare this Table with M68 (National Providers) & M71 (Regional Providers)

Another related question asked was what improvements in the process could be made. Among the suggestions where these:

- --develop specific criteria for selection
- --evaluate the performance and effectiveness of each current RTO/STO operation so as to have more concrete data on which to make decisions for re-funding
- --consider 2 or 3 year terms instead of 1 to allow for greater continuity of service.

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study" Regional Office on the subject of provider selection. (See Chapter II for an explanation about the choosing of the seven "case studies".

NEW YORK (II)

Region II personnel reported that they assessed capability of providers through several means:

- Feedback from local programs
- Site visits to local T/TA projects two times per year
- Determination of sufficient quality and quantity of the staff of potential provider
- Efforts to keep T/TA activities free from political problems
- Demonstrated experience as a provider
- Demonstrated sensitivity and commitment to Head Start.

Regional staff regarded the effectiveness of this selection process to be generally "Good" (on a scale of Excellent/Very Good/Good/Fair/Poor). One suggestion for improvement offered was that of obligating all T/TA monies for one year to SEDFRE for the purpose of training all grantees in appropriate procedure for the total T/TA needs assessment/planning/contracting/and evaluation process. Presumably, this strategy would result in overall growth in efficiency and effectiveness of the entire T/TA program throughout Region II.

PHILADELPHIA (III)

Currently in Region III, the PR&R Specialist recommends which providers will be regionally funded and the RPD makes the final decision. In the future, the PR&R Specialist will chair a panel which will make recommendations and the OCD Director (RPD) will make final decision (a contract system).

The effectiveness of the process of selecting regionally funded providers was rated as "Excellent" to "Very Good," with the exception of one particular provider selection which was given only a "Fair" rating.

A suggestion to improve the selection process by using the contract technique of RFPs was made by one respondent in Region III.

On the subject of selecting STO staff, respondents in this Regional Office reported that the institution which has the grant

(the provider) selects the STO and staff and the OCD Director (RPD) and PR&R Specialist can concur or not.

The effectiveness of this selection process was rated as "Very Good" on a scale of Excellent/Very Good/Good/Fair/Poor.

No data was received in Region III in response to whether there were any improvements to be made in the STO selection process.

ATLANTA (IV)

The selection of regionally-funded providers essentially has followed two patterns:

1. When a provider has previously given T/TA service the RO Project Officer has had opportunity to track the quantity and quality of the service and to report his recommendations to the T/TA Committee as to future use of the provider.
2. A provider who has not given service previously is evaluated by means of available information; the results are considered through the RFP/contractual process.

In both instances, the Regional T/TA Committee appears to be the decision-making body in provider selection. Considerable emphasis is placed upon the maintenance of continuity of quality services.

Regarding the selection of STO staff, they are actually hired by the grantee (e.g., the university) under a contractual arrangement; the Regional Office, however, must concur with and confirm the appointment. The effectiveness of this selection process was rated from "Excellent" to "Good" by Region IV interviewees. Some positive suggestions for improving this process were noted:

1. Systematic evaluation of STOs should be implemented
2. Should be a periodic assessment of this process of selecting STOs
3. STOs should be given more than 1 year of job security if performance is satisfactory.

CHICAGO (V)

In the past, regional providers in Region V have been selected mainly on the basis of previous funding. Initially, such criteria as professional qualifications, corporate experience, and ability to provide needed services were considered. The management staff of the Regional Office was involved in this selection process.

The effectiveness of the process of selecting regionally-funded providers was rated as "Very Good" by 2 out of 4 respondents.

Suggestions made to improve the selection process of regional providers in Region V include 1) a concerted effort to seek out and get minority contractors--to expand the variety of firms getting contracts and 2) more time to solicit tentative proposals and review those already in operation.

Very little data is available in Region V as to the selection process of RTOs. The only comment is that the two CR team leaders usually select RTOs for their own units. This selection process was rated as "Good" to "Very Good" by 1 out of 4 respondents. No suggestions for improvements were made.

DALLAS (VI)

On the question of the effectiveness of the process used for selection of regional providers in Region VI, only one respondent answered and he rated the effectiveness as being "Good" on a scale of Excellent/Very Good/Good/Fair/Poor.

On the subject of possible improvements in the selection process, again there was only one respondent, who said that the Office of Child Development should be open to the fact that other institutions and agencies exist which perhaps could provide better services than those suggested by OCD. A more open selection process is needed.

Regarding the process for selecting RTO/STO staff, interviewees in this region reported that a selection board is set up to interview applicants. Recommendations are made according to the population being served (and the need for RTO to be bilingual and bicultural), the location of RTO applicant, and his/her responsiveness. The RTO/STO grantee had an input to the recommendations, but the decision-making was left to the Regional Office staff.

Only one person responded to a question about the effectiveness of this process in Region VI, and that person rated it as "Good."

In this Regional Office, one suggestion was made regarding this selection process, namely "to streamline it to make it more effective."

SEATTLE (X)

In Region X the selection process for regionally-funded providers first involves seeing which institutions could meet the needs of Head Start programs, telling these institutions that RO was looking for new providers, inviting them to respond if they wish. Then meetings are set up with each institution that is interested, and a decision is made based on Head Start directors, staff and parents' recommendations to the Regional Office, where the PR&R Specialist and the OCD Director (RPD) make the final decision.

Of those who rated the effectiveness of the process of selecting regionally-funded providers in Region X, the consensus was that the process was "Very Good" to "Excellent."

The only improvements suggested in Region X in the selection of regional providers was to formalize the analysis process so that each institution had a common base by which to be judged. Also, the complaint of "not enough time" was mentioned.

In Region X there is open competition for the position of STATO. Program directors, parents, career development committees, etc. rate competitors 1, 2, 3 and recommend them to the Regional Office. Then

the PR&R Specialist and the OCD Director (RPD) make the final decision.

Of seven respondents in Region X, only two rated the effectiveness of the selection process of STATOs. Those ratings were both "Excellent."

There were no suggestions for improvements to be made in the selection process for STATOs in Region X.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

Regionally-funded providers are selected based on the following criteria: 1) familiarity with communities, in this case sensitivity to Indians and migrants; 2) familiarity with Head Start; 3) familiarity with child development; 4) experience and knowledge of staff; 5) professional qualification; 6) access to other resources.

A range of "Very Good" to "Fair" was given in response to rating the effectiveness of the process of selecting regionally-funded providers.

Several respondents felt improvements in the selection process of T/TA providers were necessary. A more effective system of assessing the degree to which a provider understands the need and way to deliver T/TA should be devised. Also, more flexible systems for T/TA should be developed within the context of current tribal organizations.

On the subject of the process for selection of OICS/MEDC staff, the current personnel at OICS have been on board since inception. New applicants for MEDC are screened at lower level; top candidates are sent to IMPD for concurrence. Efforts are made to avoid nepotism.

The effectiveness of these selection processes were rated as "Very Good" by one respondent while only a "Fair" rating was given by another respondent.

228

2.) Regional Provider Responses

These responses are also further divided into two parts: group one, 42 respondents from the (generally) most experienced RTO/STO/STATO/OICS network staff across the country, and group two, 77 respondents from a variety of providers: HSST/CDA, LDP, RTO/STO STATO/OICS, and state multi-state, or region-wide organizations, all of whom were chosen because they serve the local programs selected in our sample for on-site interviews. This format for presenting regional provider responses will be followed throughout this chapter on findings.

a) Group One: RTO/STO/STATO/OICS network responses (aggregated across all 11 regions)

Presented in this section is an analysis of the responses received from RTO/STO network personnel on the subject of provider selection. (See Chapter II for a detailed explanation of the selection process for these individuals.)

The respondents in this category were asked only one question in this general topic area, and that was to explain the basis on which they are assigned to particular local programs. Forty persons responded to this inquiry regarding the criteria used to assign them to grantees. Ninety-five percent cited geographic location as the relevant criterion. Two respondents advanced several "other" criteria: these included size of grantee, ability of grantee, personality of grantee, and staff makeup and needs.

b) Group two: Various regional provider responses (aggregate across seven case study regions only) presented in this section is an analysis of the responses received from the seventy-seven regional providers on the subject of provider section. (See Chapter II for an explanation of the process followed for choosing these interviewees) Regional variations in these data are highlighted as appropriate.

229

These regional providers were asked about the criteria that determined their assignment to a Regional Office or a grantee, as the case may be. The answers are given below:

Table M72a. Criteria Determining Assignment of Regional Providers (n=77)

Responses	Percent of Regional Providers Answering "Yes" (N=77)
In geographic area I serve	62.3
Need my particular expertise	72.7
Familiarity with geographic area	45.5
Familiarity with type of program	59.7
Other	28.6
Not Applicable	-
Don't Know	1.3

Note: Compare this Table with M69 regarding National Providers

Most respondents were placed because their particular expertise was needed (72.7%), but geographic location (62.3%) and familiarity with program (59.7%) also were mentioned by many providers. Responses in the "other" category (28.6%) most often included requests by local program or Regional Office, contract requirements, and, from IMPD respondents, familiarity with needs of Indians or migrants and skills needed to function in community, e.g. bilingual.

It is interesting to note that, when looking at regional variations, slightly over 60 percent of respondents indicating "yes" to the "in geographic area I serve" were from Regions IV (Atlanta) and VI (Dallas) and only 2.1 percent (1 provider out of 9) was from Region X (Seattle) and 2.1 percent (1 provider out of 4) from Region II (New York). The remainder who answered "yes" were usually about half of those providers interviewed in each region. This finding may be rooted in different mobility patterns inherent in North - South subcultures as opposed to differences in Regional Office T/TA management practices.

A comparison of group one and group two providers shows that geographic location was mentioned much more often by one group one (95.0% vs. 62.3%). Both these percents were higher than that of national providers (41.2%). Group 2 regional providers and national providers both indicated expertise most often (72.7% vs. 76.5%).

c) Local Level Responses

Local level responses on this topic of provider selection, and all other topics in this chapter on findings, are discussed first from the viewpoint of Directors, staff, parents, and (where appropriate) community leaders associated with the thirty Head Start programs sampled and then from that of local level T/TA providers.

1.) Local Program Responses

Project staff interviewed a total of 428 directors, staff and parents. (See Chapter II for an explanation of the selection process utilized).

These respondents were initially asked if they were familiar with the way that the Regional Office selects providers of T/TA. Sixty-nine percent (296 of 428) said they were not; only 15.4% (67) said they were. 15.3% said either they didn't know or the question didn't apply to them.

Then these 67 interviewees familiar with the process that the RO follows in selecting providers rated the effectiveness of it. Fifty-six of them (83.6% of the total) said they thought the process was either excellent (9), very good (23), or good (24). The other eleven said it was either fair (6) or poor (5). Compare these figures with Tables M68 (Re National Providers), M71 (Re Regional providers) and M72 (Re the RTO/STO network).

An interesting fact about those who are familiar with the RO selection process (67) is that they tend to be satisfied or very satisfied (85.1% of them) overall with their own T/TA. This can be observed in this cross tabulation:

Table M73. Cross-Tabulation: Satisfaction vs. Effectiveness of Regional Provider Selection Process

SELPROCE	TTASATIS: COUNT / ROW PCT / COL PCT / TOT PCT	30. VERY SATISFIED	31. SATISFIED	32. DISSAT-VERY DIS	ROW TOTAL
10. EXCELLENT		5	3	1	9
	ROW PCT	55.6	33.3	11.1	13.4
	COL PCT	20.0	9.4	10.0	
	TOT PCT	7.5	4.5	1.5	
11. VERY GOOD		11	12	0	23
	ROW PCT	47.8	52.2	0.0	34.3
	COL PCT	44.0	37.5	0.0	
	TOT PCT	16.4	17.9	0.0	
12. GOOD		9	12	3	24
	ROW PCT	37.5	50.0	12.5	35.8
	COL PCT	36.0	37.5	30.0	
	TOT PCT	13.4	17.9	4.5	
13. FAIR-POOR		0	5	6	11
	ROW PCT	0.0	45.5	54.5	16.4
	COL PCT	0.0	15.6	60.0	
	TOT PCT	0.0	7.5	9.0	
COLUMN TOTAL		25	32	10	67
		37.3	47.8	14.9	100.0

This table also indicates that, those most satisfied with their T/TA tend to rate the regional office selection processes the best while, conversely, those least satisfied with T/TA tend to give lower ratings to the processes for provider selection employed by the Regional Offices.

Similarly, those respondents (67) familiar with how the Regional Office selects providers and who reports the greatest impact on their program thru T/TA received are also the ones who tend to rate the Regional selection processes the highest. For example, as can be observed here in Table M74, of the 44 respondents who report a "great deal" or "quite a bit" of impact on their program by T/TA, 41 of them (93%) rate the effectiveness of the regional office selection process for providers in the positive range, i.e., "excellent", "very good", or "good".

Table M74. Cross-Tabulation: Impact vs. Effectiveness of Regional Provider Selection Process

SELPROCE	TTAEFFCT A GREAT IDEAL 20.1	QUITE A BIT 21.1	SOME 22.4	A LITTLE -NONE 23.1	ROW TOTAL
10. EXCELLENT	6	1	2	0	9
	66.7	11.1	22.2	0.0	13.4
	26.1	4.8	11.8	0.0	
	9.0	1.5	3.0	0.0	
11. VERY GOOD	10	8	5	0	23
	43.5	34.8	21.7	0.0	34.3
	43.5	38.1	29.4	0.0	
	14.9	11.9	7.5	0.0	
12. GOOD	5	11	5	3	24
	20.8	45.8	20.8	12.5	35.8
	21.7	52.4	29.4	50.0	
	7.5	16.4	7.5	4.5	
13. FAIR-POOR	2	1	5	3	11
	18.2	9.1	45.5	27.3	16.4
	8.7	4.8	29.4	50.0	
	3.0	1.5	7.5	4.5	
COLUMN TOTAL	23	21	17	6	67
	34.3	31.3	25.4	9.0	100.0

Next, all of the Directors, staff and parents were asked if they were familiar with the way in which RTO/STO network personnel are selected. 74.5% - 3 out of every 4 - were not. Only 12.4% (52 interviewees) were. The rest said they didn't know how to answer or the question didn't apply.

Then the effectiveness question was raised again in regard to RTO/STO selection - and of the 52, who did say they were familiar with the process, 48 of them (92.3%) were either satisfied or very satisfied overall with T/TA. This finding can be seen here in Table M75.

Table M75. Cross-Tabulation: Satisfaction vs. Effectiveness of RTO/STO Selection Process

SPROE	TTASATIS: VERY SATISFIED (30.)	SATISFIED (31.)	DISSAT-VERY DIS (32.)	ROW TOTAL
10. EXCELLENT	9	4	0	13
	69.2	30.8	0.0	25.0
	36.0	17.4	0.0	
	17.3	7.7	0.0	
11. VERY GOOD	7	7	1	15
	46.7	46.7	6.7	28.8
	28.0	30.4	25.0	
	13.5	13.5	1.9	
12. GOOD	6	9	0	15
	40.0	60.0	0.0	28.8
	24.0	39.1	0.0	
	11.6	17.3	0.0	
13. FAIR-POOR	3	3	3	9
	33.3	33.3	33.3	17.3
	12.0	13.0	75.0	
	5.8	5.8	5.8	
COLUMN TOTAL	25	23	4	52
	48.1	44.2	7.7	100.0

This data corresponds to that discussed previously on the relationship between RO provider selection and overall satisfaction of the respondents to the T/TA received. If those directors, staff, or parents familiar with how RTO/STO network personnel are considered, the more satisfied they are with T/TA overall, the more they tend to rate highly the RTO/STO selection process.

Similarly, those interviewees (52) familiar with how the RTO/STO network personnel are selected and who report the greatest impact on their program thru T/TA received, are also the ones who tend to rate the RTO/STO selection processes the highest. For example, as can be seen here in Table M76, of the 43 respondents

Table M76. Cross-Tabulation: Impact vs. Effectiveness of RTO/STO Selection Process

	TTAEFFCT				
COUNT / ROW PCT / COL PCT / TOT PCT	20. IDEAL	21. QUITE A BIT	22. SOME	23. A LITTLE -NONE	ROW TOTAL
SPROE					
10. EXCELLENT	10	2	1	0	13
	76.9	15.4	7.7	0.0	25.0
	41.7	10.5	12.5	0.0	
	19.2	3.8	1.9	0.0	
11. VERY GOOD	6	6	3	0	15
	40.0	40.0	20.0	0.0	28.8
	25.0	31.6	37.5	0.0	
	11.5	11.5	5.8	0.0	
12. GOOD	8	5	2	0	15
	53.3	33.3	13.3	0.0	28.8
	33.3	26.3	25.0	0.0	
	15.4	9.6	3.8	0.0	
13. FAIR-POOR	0	6	2	1	9
	0.0	66.7	22.2	11.1	17.3
	0.0	31.6	25.0	100.0	
	0.0	11.5	3.8	1.9	
COLUMN TOTAL	24	19	8	1	52
	46.2	36.5	15.4	1.9	100.0

who report a "great deal" or "quite a bit" of impact on their program by T/TA, 37 of them (86%) rate the effectiveness of the selection process for RTO/STOs in the positive range, i.e., "excellent", "very good", or "good".

The small number of respondents who are familiar with regional provider and RTO/STO selection processes points up the main finding here it is apparently a mystery to most local level program personnel just how their Regional Office picks providers for delivering T/TA. It should be recalled, however, that the responses of parents, since they are being considered here right along with those of Directors and staff, might be clouding the picture as to how much knowledge there is at the local level regarding RO level procedures for provider selection. On the other hand, given Head Start's emphasis on parent involvement, perhaps this caveat on interpreting their data should not be considered too strongly - leaving the focus on the essentially little knowledge filtering down from the regional level to the local on how regional providers - who will service local programs - are actually selected.

2.) Local Provider Responses

Local providers were asked questions relating to T/TA management activities, among them one which sought information about the criteria that determined their assignment to a grantee. The answers are given below:

Table M76a. Criteria determining Assignment of Local Providers (n=24)

Response	Percent of Local Providers Answering "Yes"
In geographic area I serve	54.2
Need my particular expertise	70.8
Familiarity with geographic area	54.2
Familiarity with type of program	54.2
Other	4.2
Not applicable	-
Don't know	4.2

Note: Compare this Table with M69 on National Providers & M72a on Regional Providers.

The majority of local providers (70.8%) indicated their hiring was a result of the need for their particular expertise. This frequency of response is virtually the same for all categories of providers, and constitutes the primary reason for most being assigned or hired.

Summation of M4 Findings: Provider Selection

The question addressed in this section was "is an appropriate and effective T/TA provider selection process in place?"

If the opinions of the National and Regional office staff interviewed are considered, the finding emerges that they perceive the provider selection processes employed by Head Start to be quite effective. Eighty percent (80%) of the OCD HQ officials, (see table M68), and 88% of the RO staff who were interviewed (see TAble M71) reported that the effectiveness of these processes was "excellent, very good, or good." The fact that the national percentage (80%) falls slightly below the regional one (88%) suggests that comparitively, the OCD HQ officials are somewhat less satisfied with those procedures followed in picking national providers.

On the local level, one key finding that emerged on this topic from the interviews conducted at the 30 program sites is that approximately 7 out of 10 respondents were not at all familiar with how their Regional Office selects T/TA providers to serve them. Specifically, 75.5% had no idea how RTO/STO network personnel were picked and 69.0% said they didn't know how the RO chose various regional providers. This suggests not just that there exists a lot of ignorance about how the suppliers of T/TA are selected, but more importantly that they - the consumers at the local level - are probably not being allowed to have any significant role in the process of selection.

Another key finding that emerged on the local level with Head Start staff and parents is that among those who were familiar with how regional providers of T/TA got selected, 83.6% rated the effectiveness of the process as "excellent, very good, or good." This percentage is very much in line with those of the National (80%) and Regional (88%) level officials.

A bivariate analysis of these local people who said they were familiar with the way in which the regional providers were selected showed that they tended to be more satisfied overall with their own T/TA than those unfamiliar with how regional providers are chosen. This is mentioned as added reason for allowing local program people to become familiar with and involved in the selection process for regional providers.

This topical question on provider selection was thought to be not appropriate for asking the providers themselves. Instead they were queried on what process was followed in assigning them to particular regional offices or local grantees after they had been selected. The single most frequently mentioned factor was the particular expertise of a provider. Seventy-seven percent (76.5%) of the national providers, 72.7% of the regional providers, and 70.8% of the local providers all mentioned this as the most important criterion affecting their assignment to particular regional offices or local grantees.

On the whole, the provider selection process in place at the various levels seems sound (as does the process for assignment of providers). Improvement could profitably come from qualitative upgrading of the system and not overhauling of the system. Among the possible qualitative improvements that deserve consideration are better mechanisms and criteria for assessing the capabilities of providers and better procedures for involving more key personnel in the selection processes.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION M5: Are appropriate and effective quality controls exercised, e.g., reporting and monitoring

KAI staff believed this question was also a vital one. Once T/TA needs have been determined, T/TA plans devised, and T/TA providers selected to fill the needs according to the plan, it is essential that some sort of on-going tracking of the providers' progress be carried out. This is to ensure "quality control." It can include many possible techniques, but commonly, it involves reporting and monitoring. Whatever form it takes, control of the providers is another major indicator of the way in which Head Start manages its T/TA.

In this section, the topic of control of providers will be discussed at the national, regional, and local levels.

a. National Level Responses

National level responses on this topic of control of providers, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoints of OCD Headquarters officials and then from that of national T/TA providers.

1) OCD Headquarters Responses

To start off on this subject, all Headquarters interviewees were asked to describe the overall process used to track the delivery of T/TA at the national, regional, and local levels.

Central office respondents cited several ways in which T/TA services were controlled and monitored at the three levels.

Nationally

1. T/TA Consumer Reports.
2. Day-to-day (or regular interval) technical direction by Project Office, often informal in nature.
3. Monthly written reports usually required from all T/TA providers.
4. Quarterly written reports usually required from all T/TA providers.

5. Written and informal feedback from Regional Office to Central Office.
6. Through awarding of monitoring contracts--or a firm monitoring requirement is built into T/TA service contract.
7. Conferences and workshops with OCD staff and providers to review procedures.
8. Site visits utilized for some activities.

Regionally

1. The PR&R Specialist works in conjunction with Community Representatives and other relevant staff personnel to form a monitoring T/TA team at the regional level.
2. Periodic written reports to central headquarters.

Locally

1. Local project T/TA consumers make reports and recommendations to the Regional Office.
2. Site visits from Regional and National Offices.
3. T/TA Evaluation conferences.
4. Monitoring T/TA contract.

In general, the central office respondents were knowledgeable about the various processes used at the different levels to control and monitor T/TA efforts.

Central office respondents tended to regard the effectiveness of the tracking system at the national level to be "Excellent" and "Very Good". Respondents' views of the regions' effectiveness of T/TA tracking clustered in the "Good" to "Fair" range.

Among the improvements needed to further enhance the T/TA provider control system, as perceived by the central office staff, are the following:

Nationally

1. Put into operation new guidelines (draft copy dated 6-15-74) regarding monitoring T/TA providers.
2. Additional staff needed.
3. Need cost benefit analysis system.
4. Need comprehensive management information system.
5. Need for coordination among T/TA providers who now tend to work independently.
6. Need for a standard monitoring format.

Regionally

1. Need more guidance from National Office on monitoring processes.
2. Need a cost benefit analysis system.
3. Need a management information system.

Locally

1. Need for more guidance from Regional Office on monitoring processes.
2. Need cost benefit analysis system.
3. Need management information system.

2) National Provider Responses

These 34 respondents were asked to indicate whether or not any control mechanisms were imposed upon them. Specifically, they were queried about whether or not they personally submitted written reports after completion of their activities. There responses were:

Table M77. Written Reports Submitted After Completion of Activities: National Providers (n=34)

Responses	Percent
Yes	91.2
No	8.8

The vast majority indicated "Yes." Those who said "Yes," then indicated to whom and how often these reports were submitted. Table M78 presents this data:

Table M78. Percent of National Providers Submitting Written Reports to Specific Recipients and Report Frequency (n=34)

Recipient of Written Report Following Activities	Percent of National Providers Submitting Reports	Frequency of Submission				
		Monthly	Quarterly	Semi-Annually	Annually	Other
Employer	55.9	11.8	8.8	--	--	35.3
Policy Advisory Board	--	--	--	--	--	--
Grantee Board	11.8	--	--	--	--	11.8
State T/TA Grantee	8.8	2.9	--	--	--	5.9
Regional Office	32.4	2.9	2.9	--	--	26.5
National Office	52.9	11.8	14.7	2.9	5.8	17.6
Part of Grants Application	2.9	--	2.9	--	--	--
Part of Contract Requirements	5.9	--	2.9	--	--	2.9
Other	17.6	5.9	5.9	--	--	5.9

(All percentages are based on the total number of national providers. Because this question permitted multiple responses for the recipient answers only, no percent in that column equals 91.2%, the number answering "Yes" to the preceding question. Respondents were allowed to indicate only one frequency for each recipient, so the percentages in each frequency row total the percentage submitting reports to that particular recipient.)

The majority of national providers who wrote activities reports submitted them to their employer (55.9%) and the national office (52.9%).

Nearly one-third (32.4%) gave them to the regional office. The recipients named in "Other" (17.6%) included local program, workshop participants, and National Institutes of Education.

Regarding the frequency of submission, just over one-third who submitted reports to their employer and half the respondents who submitted reports to the national office did it monthly or quarterly. But the most common response here for nearly all recipients was "Other." Most respondents designating "Other" said that after each visit or training session a written report was submitted. The rest of "Other" responses were final or intermittent report and whenever necessary.

So the primary patterns evidenced here are that reports generally were submitted to the employer, national, and regional offices on a monthly or quarterly basis and after a site visit. The data does not show how many employers or how many regional offices in turn submit reports to the national office. If this did occur, the percent of those reporting to national would increase. But, if it is a fairly accurate reflection of reality that only 52.9% sent reports to national, then the control functions of national OCD over its providers were lax.*

This data from national providers should be compared to that reported earlier from OCD Headqaurters officials. The officials interviewed in the National Office tended to classify their tracking system as excellent or very good. However, the national providers supplied information about their reporting requirements that raise questions as to how effective OCD Headquarters actually is controlling its providers. Even though OCD Headquarters officials tended to rate their system's effectiveness very highly, they did mention a number of possible improvements in their system for provider control. Four of their six suggestions spoke directly to better coordination of the activities of their providers, either via better monitoring or via a comprehensive management information system.

This information presented in Table M77 should also be considered in tandem with that presented earlier in Table M9 on "Percent National

* In fairness, it should be pointed out that staff and director responses to this question have not been separated; presumably the directors would be more responsible for reporting. Hence, caution is advised in interpreting these data.

Providers Submitting T/TA Work Plan." Recall that, given the most liberal intergretation of that table, at most 65% of the national providers interviewed had to submit any T/TA work plan. Couple that finding with this present one indicating that only 53% of them had to submit reports to OCD Headquarters, and it becomes possible to state with ever greater emphases that National Office controls over its providers do not seem to be as stringent as they should be.

b. Regional Level Responses

Regional level responses on this topic of control of providers, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1) Regional Office Responses

These responses are further divided into two parts: an aggregated analysis of responses from all 11 regions from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter on findings.

a) Aggregated analysis of all 11 regions

(See Chapter II for an explanation of the selection process for interviewees in the Regional Offices.)

First, on the subject of whether or not improvements in the way providers are controlled are needed, 13 regional respondents offered their opinions. The frequencies of their answers were:

Table M79. RO Respondents in Control of T/TA--Need for Improvements

Responses	Frequency
Yes	9
No	2
Don't Know	2
Total	13

(n=64, many of whom did not respond)

Comments offered on how to improve the control process fell into three discrete areas, which are listed here along with some specific comments made relating to each:

- coordination (e.g., scheduling) could be strenghtened by centralizing the responsibility for such activity in one person, e.g. the PR&R Specialist,
- reporting requirements could be clarified further, in such a way to facilitate consistent reports within and across regions.
- monitoring merits increased attention but can be given it only if additional manpower is made available to the regions.

All other comments made on the subject of controlling providers that didn't fit solely into the three sub-categories of coordination, reporting, and monitoring clustered around two recommendations which could apply to all or any of the sub-categories:

- communications: greater delineation of what is needed from the providers for purposes of controlling their activities; setting out why the expectations are what they are; settling on who exactly is responsible for making and implementing these decisions.

- manpower: since current RO workloads tend to preclude much on-site visiting, according to the comments consistently made by those interviewed, it was frequently suggested that additional staff would provide the only means to achieve the end of better controlling of providers.

Those providers were required to report in the same way. Twenty-one T/TA persons answered. Their responses divided in this way:

Table M80. Uniformity of Provider Reporting: RO Respondents

Responses	Frequency
Yes	18
No	2
Don't Know	1
Total	21

(n=64, not all of whom were asked to respond)

Further, they were asked about the content of such reports. Their answers were: (multiple responses allowed).

Table M81. Contents of Provider Reporting: RO Respondents

Responses	Frequency
Number of trainees served	12
Subjects covered	12
Person days spent giving T/TA	11
Budget figures	11
Materials used	9
Evaluation	7
Other	5

(n=64, not all of whom were asked to respond)

The "other" comments included problems incurred, results of pre- and post-assessments, and projected activities for the coming months.

Next, regional respondents were asked about the need to improve the process for monitoring the delivery of regional T/TA providers. Their answers were these:

Table M82. Need to Improve Providers Reporting: RO Respondents

Responses	Frequency
Yes	9
No	3
Total	12

(n=64, not all of whom were asked to respond)

Even though we have a case of a small "n" here, a noteworthy pattern of responses emerges nonetheless, i.e., three out of every four thought improvement was needed in the monitoring of the delivery of T/TA providers.

When asked for concrete suggestions on how to achieve the needed improvement, a wide range of ideas were offered, including:

- significantly more on-site monitoring and less dependence on written reports
- more and regular meetings involving appropriate Regional Office staff and the providers
- greater delineation by the Regional Office of expectations, priorities, etc. of providers
- centralizing into one person the responsibility in a region for monitoring providers (e.g., PR&R Specialist)

It appears noteworthy that these various suggestions support or extend those made previously on the subject of overall control of providers. The consistency of responses in both areas appears to confirm the validity of the suggestions.

Regional respondents were asked to change their focus and explain if their local grantees collected data themselves on the delivery of T/TA to their program by national providers. Of the 18 who answered, their responses were:

Table M83. Local Grantee Collection of National Providers Data: RO Respondents

Responses	Frequency
Yes	11
No	5
Don't Know	2
Total	18

(n=64, not all of whom were asked to respond)

Then they were asked how this data was gathered by the local programs and used, if at all, by the Regional Office. The answers to this were varied but included these differing approaches:

- local T/TA reports are sometimes channelled directly to the Regional Office via Community Representatives or PR&R or STATO
- local T/TA reports are used only by the Head Start program in devising its T/TA plan--RO sees only the results of such T/TA reports as they are reflected in the local program's plan
- local T/TA reports are only informally communicated to the Regional Office, i.e., should a problem arise requiring intervention by a CR or PR&R Specialist, etc.
- local T/TA reports are not used by the Regional Office.

This diversity of response seems to indicate lack of consistency nationwide on the use by regions of data collected at the local level

regarding T/TA provided by national providers. Also, these particular findings do not show whether the regions used the data received, i.e., whether they kept it for their own use or passed it along to the appropriate national providers.

Regional respondents were asked if their local program grantees collected data themselves on the delivery of T/TA to their programs by regional providers. Of those who were asked this question, six responded:

Table M84. Local Grantee Collection of Regional Provider Data: RO Respondents

Responses	Frequency
Yes	5
No	1
Total	6

(n=64, not all of whom were asked to responded

They were also asked how this information was gathered and used by the Regional Office, if at all. The respondents indicated that a wide variety of methods are used, some of which are formal and others relatively informal. One method mentioned was the use of a form supplied by the provider to the grantees. A copy of the completed form is sent to the project manager in the regional office; and ultimately the provider sends a composite of all evaluations to the Regional Office. Other methods included collection of information from the states and feedback from regional providers; and monthly reports submitted by the local grantee. Several respondents also listed informal methods such as discussion between providers or grantees and the Regional Office.

What all of this information on local grantees collecting data on T/TA supplied by either national or regional providers seems to indicate is that there is no uniform system in place to facilitate the tracking or controlling by the regional offices of T/TA being delivered to their local programs. Granted, there are apparently several quality control strategies being employed in various places, but there seems to be no comprehensive system that could be fed into all programs either within a region or across all regions.

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of persons interviewed in each "case study" Regional Office on the subject of control of providers. (See Chapter II for an explanation about the selection of the "case studies.")

NEW YORK (II)

The current process of tracking T/TA activities throughout the region appears to be simply the schedule and monthly reports from the provider himself. Some feeling was expressed that a complete management system of T/TA provision would require staff allocation considerably greater than now exists. Particularly noted was the needed capability for more on-site visits by Regional Office staff including the inclusion of Regional Office personnel in local program T/TA activities.

Philadelphia (III)

Data from Region III indicates that all providers are required to report in the same way. Topics covered in reports by regionally-funded providers include such items as budget, man-days spent, number of trainees, subjects covered and materials used.

No improvements were deemed necessary in the process currently employed to track T/TA providers at the regional level but this might change in the future following the changeover from the grants system to contracts.

On the specific subject of monitoring providers, very little data was offered in Region III, but one respondent indicated no improvements were necessary in the current process of monitoring the delivery of T/TA by regionally-funded providers.

In Region III, grantees, particularly directly-funded programs, collect data on the delivery of T/TA to their programs. This information is in the form of reports given to the PR&R Specialist concerning the effect of the T/TA provided.

ATLANTA (IV)

In the tracking of RO funded providers, reports are required monthly on the following dimensions:

- Man-days spent per activity
- Number of trainees addressed
- Subjects covered
- Materials used and/or developed
- Specific problems encountered
- Assessment of project to date
- Next month's activities

If a problem occurs in the delivery of T/TA the CR tracks the problem on-site; when necessary, the PR&R office then deals directly with the provider.

In addition, local program people have forms given by the provider to receive feedback from the consumer; copies of these reports are usually sent to the Regional Office.

CHICAGO (V)

There is conflicting information as to the regularity of the written reports required of providers in this region. One respondent says they are all required to report with the same frequency, and another says that Roosevelt University reports quarterly while EPI (Edutational Projects Inc.) gives an on-going assessment via task-oriented workshops as well as quarterly reports.

All regionally-funded providers submit reports addressing such topics as budget, man-days spent, number of trainees, subjects covered, materials used, the amount of training and number of sessions, and the consumer's evaluation.

The suggestions for improvement to be made in the process of tracking T/TA providers at the regional level include ironing out problems between state providers and local grantees, particularly in the area of fiscal control and program accountability.

Data gathered shows that in the past there were few means of monitoring on regional level training bought by local programs, and that funding cycles overlapped, making any monitoring of delivery of T/TA by regional providers difficult.

Local grantees do collect data on delivery of T/TA to their programs and some feed it back through states to the Regional Office. This has resulted in some changes in the FY 75 plan. The region-wide providers (Roosevelt and EPI) got regular feedback from local grantees.

DALLAS (VI)

On the subject of whether or not all providers in this region are required to report in the same way, data collected showed the answer to be yes. In Region VI, regionally-funded providers make out reports on a monthly basis, covering such topics as budget, man-days spent, number of trainees, subjects covered and results. These monthly reports are taken directly from trip reports made by the regionally-funded providers each time they go into the field. Thus the Regional Office has a very good idea of what is going on in local programs.

An improvement suggested in Region VI in the process of controlling T/TA providers at the regional level is to increase the manpower to work with the providers and assist them in assessing their capabilities. More manpower would also allow for a continuity of management and therefore more efficient management of T/TA providers at the regional level.

While some respondents in Region VI are generally satisfied with the process of monitoring the delivery of T/TA by regionally-funded providers, others feel that a generalized monitoring instrument based on performance standards would be very useful. The grantee could fill out a form and have it ready with documentation when a team from the Regional Office would make on-site visits, do their own assessment, and together with grantee's evaluation, recommendations would be drawn up. These recommendations could then be sent back to the T/TA providers, the RTOs, and to the local programs.

Respondents in this region were then asked if local grantees collect data on the delivery of T/TA to their program and, if so, how this information from the grantees is gathered and used by the Regional Office. Some said that information from the grantees is gathered through monthly reports as to the kinds of services they have received and their efforts to evaluate these services. Others in Region VI said that grantees did collect data on the delivery of T/TA to their program but they "didn't have the faintest idea how." There is a feeling among the respondents that the Regional Office does not have time to use these monthly reports, and that better analysis leading to better services could be accomplished if RO had time to use the reports.

SEATTLE (X)

Data gathered in Region X shows that all providers are required to report in the same way. Reports are submitted quarterly by regionally-funded providers. These reports include such topics as budget, man-days spent, number of trainees, subjects covered, materials used, local of training and evaluation.

According to data provided by Region X, improvements could be made in the process of controlling T/TA providers at the regional level if more manpower was available to do more field work with the providers. This would allow for an on-going response to their needs instead of just crisis reaction.

Improvements suggested in the process of monitoring the delivery of T/TA by regionally-funded providers also involves more on-site visiting, and more meetings (bi-monthly instead of quarterly). It is recognized, however, that this involves more manpower and therefore may be too costly.

There is a difference in interpretation as to whether local grantees collect data on the delivery of T/TA to their programs in Region X. One response is yes, that information is gathered by STATO, and that each STATO has a system for this. The other response is no, except if it is in their work program as part of a grant application.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

All providers are required to report in the same way according to the responses given in this division. Topics covered in provider reports include such topics as budget, T/TA provided, man-days spent, number of trainees, subjects covered, materials used, improvements needed, program observation, personality conflicts and evaluations. Almost all providers have participants complete an evaluation form which is then reviewed by the provider.

Regarding possible improvements in the control of T/TA providers, it is suggested that a T/TA specialist be designated to be in charge of management of T/TA providers at the regional level. Currently, there are people who do this but they have other responsibilities too, and it is felt they should be freed from other responsibilities to concentrate on T/TA. Also, a clearer definition of what the T/TA plan called for, so products (T/TA) would be more consistent is suggested.

Then, on the specific subject of possible improvements in the monitoring of the delivery of T/TA, it was suggested that a specialist should be appointed in OICS and in MEDC to keep close track of delivery of T/TA. A more systematic monitoring system should be established with clear understanding of who has responsibility for what.

Grantees do collect data on the delivery of T/TA to their program informally via their local T/TA plan. The Regional Office (division) gets this information through the CR, however it is noted that due to the current IMPD structure, little is done with this information.

2. Regional Provider Responses

These responses are also further divided into two parts: group one, 42 respondents from the (generally) most experienced RTO/STO/STATO/OICS network staff across the country, and group two, 11 respondents from a variety of providers: HSST/CDA, LDP, RTO/STO/STATO/OICS, and state multi-state, or region-wide organizations, all of whom were chosen because they serve the local programs selected in our sample for on-site interviews. This format for presenting regional provider responses will be followed throughout this chapter on findings.

a. Group One: RTO/STO/STATO/OICS network responses (aggregated across all 11 regions)

Presented in this section is an analysis of the responses received from RTO/STO network personnel on the subject of needs assessment and T/TA planning. (See Chapter II for a detailed explanation on the selection process for these individuals.)

On this topic, the respondents were asked mainly about reporting requirements with which they must comply. First they were queried regarding submission of reports to their employers, i.e., the university, agency, or private firm involved.

Eighty-seven percent of the 39 persons who responded to this question indicated that they did submit a written account of their activities to their employers. As indicated in the chart below, monthly or quarterly reports were most prevalent.

Table M85. RTC Network Employer Reporting Practices (n=34/42)

Region	# of Responses	# of responses by type of reporting system							
		Weekly	Monthly	Quarterly	Yearly	Monthly and Quarterly	Monthly and Yearly	Quarterly and Yearly	Monthly Quarter & Yearl
II	2		2						
III	3		1	1		1			
IV	8		4	1		1			2
V	4		1	2		1			
VI	5		1	1	1	1		1	
VII	3		1	1			1		
VIII	2			1		1			
IX	2	1						1	
X	2	1						1	
HPD	3		1	2					
National Total	34	1	11	10	1	5	1	3	2
%	100.0	2.9	32.4	29.4	2.9	24.7	2.9	8.8	5.9

All respondents except one (Utah) reported that they submit written reports to the Regional Office. The frequency with which reports are submitted is shown in the table below:

Table M86. RTO Network Regional Office--Reporting Practices (n=40/42)

Region	# of Responses	# of responses by type of reporting system						
		Monthly	Quarterly	Other	Monthly and Quarterly	Monthly and Other	Quarterly and Other	All Three
II	2	2						
III	6		4		1			1
IV	7	1	2			4		
V	6		6					
VI	4	3			1			
VII	4	2	2					
VIII	2		1		1			
IX	3		3					
X	3		3					
IMPD	3		3					
Nat'l Total	40	8	24	0	3	4	0	1
%	100%	20%	60%	0	7.5%	10%	0	2.5%

Quarterly reports or monthly reports were the predominant mode of information/communication vis-a-vis the Regional Office, the same pattern as was evidenced on the previous item, vis-a-vis the employers of the RTO/STO staff.

b) Group Two: Various Regional Provider Responses (aggregated across seven case study regions only

Presented in this section is an analysis of the responses received from the 77 regional providers on the subject of control of providers. (See Chapter II for an explanation of the selection process for these individuals.) Regional variation in these data will be highlighted as appropriate.

When regional providers from the case study regions responded to the question about whether or not they submitted written reports after they had completed their activities, their answers were:

Table M87. Written Reports Submitted After Completion of Activity: Regional Providers (n=77)

Responses	Percent
Yes	92.2
No	7.8

NOTE: Compare this Table with Table M77 on National Providers

Virtually all these providers answered "Yes." This figure is comparable to that for national providers (91.2%).

Next these respondents were asked to whom and how often they submitted reports. Table M88 presents the recipients and frequency of submission to each recipient.

Table M88. Percent of Regional Providers Submitting Written Reports to Specific Recipients and Report Frequency, (n=77)

Recipient of Written Report Following Activities	Percent of National Providers Submitting Reports	Frequency of Submission				
		Monthly	Quarterly	Semi-Annually	Annually	Other
Employer	35.1	19.5	5.2	--	--	9.1
Policy Advisory Board	19.5	5.2	7.8	--	1.3	3.9
Grantee Board	14.3	6.5	1.3	--	1.3	3.9
State T/TA Grantee	19.5	9.1	2.6	1.3	1.3	5.2
Regional Office	70.1	29.9	28.6	2.6	2.6	5.2
National Office	6.5	1.3	1.3	--	1.3	2.6
Part of Grants Application	14.3	2.6	1.3	--	10.4	--
Part of Contract Requirements	5.2	3.9	1.3	--	--	--
Other	15.6	3.9	1.3	--	--	10.4

NOTE: Compare this Table with Table M78 on National Providers

(All percentages are based on the total number of regional providers. Because this question permitted multiple responses for the recipient answers only, no percent in that column equals 92.2%, the number answering "Yes" to the preceding question. Respondents were allowed to indicate only one frequency for each recipient, so the percentages in each frequency row usually total the percentage submitting reports to that particular recipient. Exceptions occur for employer, policy advisory board, grantee board, and regional. In each of these instances, one respondent knew that that agency got a written report, but he/she did not know the frequency of submission.)

Most respondents submitted reports to the regional office (70.1%) and the next highest number submitted reports to their employer (35.1%). The category "other" usually referred to RTO/STO director (or the equivalent), as distinct from employer--the T/TA grantee.

Frequency of report submission was primarily either monthly or quarterly to all recipients. "Other" frequency normally referred to report submitted "after training activity completed" or "upon request."

It is appropriate to compare national provider responses with reporting requirements vis-a-vis the office that hires the providers. Thus, 52.9% of national providers sampled submitted reports to the national office and, of these, half submitted them either monthly or quarterly, and one-third either after each visit, at end of contract, or whenever necessary. Of regional providers, 70.1% submitted reports to the regional office, and over four-fifths submitted them either monthly or quarterly. It appears that, overall, regional offices had a more uniform and systematic procedure for reporting than did the national office.

The Regional Offices show some variance with respect to the frequency of reports on the activities of their providers. Within each region the percentage of providers submitting monthly or quarterly reports was:

Region II (New York)	100.0%
Region III (Philadelphia)	74.4%
Region IV (Atlanta)	44.4%
Region V (Chicago)	50.0%
Region VI (Dallas)	71.4%
Region X (Seattle)	44.4%
Region XI (IMPD)	50.0%

Even allowing for reports submitted monthly or quarterly to the Regional Office as part of grants application or contract requirements, the data shows that, among our sample, only some regions (II, III, and VI) required frequent, systematic reporting of all or most provider activities.

c. Local Level Responses

Local level responses on this topic of control of providers, and all other topics in this chapter on findings, are discussed first from the viewpoint of Directors, staff, parents, and (where appropriate) community leaders associated with the 30 Head Start programs sampled and then from that of local level T/TA providers.

1. Local Program Responses

Project staff interviewed a total of 428 directors, staff, and parents. (See Chapter II for an explanation of the selection process utilized.)

By way of getting insight into how much attempt is made by local programs to collect data regarding provision of T/TA, the question was asked "do you submit a written report about the T/TA activities in your local program?" Nearly one-half (48.6%) of the respondents said yes; four out of ten (40.4%) said no. 10.9% answered either "don't know" or doesn't apply."

Region IV Atlanta had the largest number of respondents who said yes, 66.2%; IMPD interviewees said yes with a 59% frequency rate--both of these are considerably higher than the "norm" of 48.6% reached by aggregating all the regional responses.

Region V Chicago had the largest percentage of "no" answers (57.1%) indicating that most respondents in that region apparently do not submit T/TA reports to the extent the other sampled regions do.

A second form of analysis of this data involved the cross tabulation of these results with the data obtained on the level of satisfaction and the level of impact with T/TA received by these same respondents (see Section E 1). These cross tabulations are presented here in Table M89.

Table M89. Cross Tabulation: Satisfaction and Impact vs. Report Submission

Satisfaction

		TTASATIS			
	COUNT / ROW PCT / COL PCT / TOT PCT	VERY SAT	SATISFIED	DISSAT-V DIS	ROW TOTAL
		30.1	31.1	32.1	
WRITREPT					
YES	1.	78	96	29	203
		38.4	47.3	14.3	55.6
		65.5	50.0	53.7	
		21.4	26.3	7.9	
NO	2.	41	96	25	162
		25.3	59.3	15.4	44.4
		34.5	50.0	46.3	
		11.2	26.3	6.8	
COLUMN TOTAL		119	192	54	365
		32.6	52.6	14.8	100.0

Impact

		TTAEFFCT				
	COUNT / ROW PCT / COL PCT / TOT PCT	A GREAT IDEAL	QUITE A BIT	SOME	A LITTLE -NONE	ROW TOTAL
		20.1	21.1	22.1	23.1	
WRITREPT						
YES	1.	70	66	53	16	205
		34.1	32.2	25.9	7.8	56.6
		59.8	58.9	52.5	50.0	
		19.3	18.2	14.6	4.4	
NO	2.	47	46	48	16	157
		29.9	29.3	30.6	10.2	43.4
		40.2	41.1	47.5	50.0	
		13.0	12.7	13.3	4.4	
COLUMN TOTAL		117	112	101	32	362
		32.3	30.9	27.9	8.8	100.0

These data show that among the dissatisfied or very dissatisfied on the satisfaction scale and among those who said "a little" or "none" on the impact scale, it does not seem to make any difference whether or not a written report on T/TA activities is submitted. There are roughly as many (percentage-wise) who do not submit reports on the negative ends of these scales as there are those who do submit them--hence, it is not feasible to draw a solid conclusion from this part of the data.

However, if only the very satisfied are considered (119), those who submit reports outnumber those who do not almost by a two to one margin (78 - 41). Also, if only the interviewees who reported "a great deal" of impact due to T/TA are considered (117) again many more submit reports on T/TA than do not (70 - 47). This part of the data seems to indicate a positive relationship between having to submit T/TA reports and either being satisfied with T/TA or believing it has great impact on the local program.

An attempt was made to get more specific information on this reporting by local programs regarding T/TA activities. Each respondent was asked to indicate if reporting was made to Policy Advisory Councils, Grantee Boards, State T/TA Grantees, Providers involved, the Regional Office, or elsewhere. The results of this questioning are displayed here in matrix form, Table M90.

Table M90. Matrix of Type of Frequency of Local T/TA Reporting

Recipient	Responses	Frequency of Reporting			
	# Yes / % Yes	Monthly	Quarterly	Post T/TA*	Annually
PAC	68 / 15.9%	45.6	8.8	17.6	22.1
Grantee Board	38 / 8.9%	37.8	13.5	18.9	21.6
State T/TA Grantee	42 / 9.8%	36.6	12.2	19.5	24.4
Provider Involved	41 / 9.6%	19.5	4.9	56.1	9.8
OR	72 / 16.8%	25.0	16.7	18.1	38.9
Other	95 / 22.2%	35.8	6.3	21.1	12.6

* Post T/TA means that a report is submitted after the T/TA has been delivered.

Generally, it seems apparent that among those who submit some sort of written report on their T/TA, the Regional Office (16.8%) and the Policy Advisory Council (PAC) (15.9%) are the most frequently-mentioned recipients of the reports.

Region II New York respondents reported sending written reports to the PAC more (31.8%) than any other region studied or the norm of 15.9%.

Region III Philadelphia and Region VI Dallas interviewees mentioned sending written reports to their state T/TA grantees more (16.7% and 15.4% respectively) than the other five regions studied or the "norm" of 9.8%.

Region VI Dallas Directors, staff, and parents said they sent written T/TA reports to the Regional Office (38.5% response frequency) more than any other region or the "norm" of 16.8%.

2. Local Provider Responses

When local providers were queried about whether or not they submitted written reports after they completed their activities, their responses were:

Table M91. Written Reports Submitted After Completion of Activities: Local Providers (n=24)

Responses	Percent
Yes	75.0
No	25.0

NOTE: Compare this Table with Table M77 (national providers) and Table M87 (regional providers)

While three-forths did submit reports, this percent is lower than for either regional (92.2%) or national (91.2%).

Those local providers who said "Yes" then identified who received those reports and with what frequency, shown in Table M92:

Table M92. Percent of Local Providers Submitting Written Reports to Specific Recipients and Report Frequency (n=24)

Recipient of Written Report Following Activities	Percent of Local Providers Submitting Reports	Frequency of Submission				
		Monthly	Quarterly	Semi-Annually	Annually	Other
Employer	50.0	8.2	--	4.2	16.7	20.8
Policy Advisory Board	4.2	4.2	--	--	--	--
Grantee Board	12.5	4.2	--	--	4.2	4.2
State T/TA Grantee	8.3	--	--	--	8.3	--
Regional Office	12.5	--	--	--	12.5	--
National Office	--	--	--	--	--	--
Part of Grants Application	12.5	--	--	--	12.5	--
Part of Contract Requirements	29.2	4.2	--	4.2	16.7	4.2
Other	25.0	4.2	8.3	--	--	12.5

NOTE: Compare this Table with Table 78 (national providers) and Table M88 (regional providers)

(All percentages are based on the total number of local providers. Because this question permitted multiple responses for the recipient answers only, no percent in that column equals 75.0%, the number answering "Yes" to the preceding question. Respondents were allowed to indicate only one frequency for each recipient, so the percentages in each frequency row total the percentage submitting reports to that particular recipient.)

Half the local providers submitted reports to their employer (commonly a university, college, health agency or center, or social services agency).

Among those who mentioned part of grants application (12.5%) and contracts requirements (29.2%), it may be that the local grantee ultimately got written reports, but several respondents did indicate under "other" that Head Start directors or local centers received them. It is difficult to say precisely how many local grantees finally got written reports.

The frequency of submission was primarily annually or other (either after site visit or as requested) to most recipients. Monthly reporting was less common.

Overall local providers appear to be subject to less frequent and systematic reporting requirements than either regional or national providers.

Summation of M5 Findings: Control of Providers

The topical question addressed in this section was "are appropriate and effective quality controls over T/TA exercised, e.g., reporting and monitoring?"

On the national level, KAI discovered a sharp disparity between the rather glowing ratings (very good to excellent, usually) by OCD HQ respondents on the effectiveness of their overall process to control providers and the reports from the national T/TA providers sampled that only roughly half of them submit reports to the National Office (see Table M78). Couple this finding with that uncovered earlier in Section M3 that only 65.0% (at most) of these providers have to submit a work plan to the National Office (see TAble M32) for their T/TA activity, and we are able to state rather firmly that, in spite of the favorable comments reported by the OCD officials interviewed, Head Start HQ is not apparently controlling its national providers as effectively as it could.

There are of course many national providers who do make out work plans, who do submit reports regularly to the National Office, and who receive generally high marks from the consumers for the T/TA they deliver. Yet they seem to be fewer in number than would be expected. This is particularly the case in view of the initiatives taken in recent years by OCD HQ on such fronts as needs assessment policy, T/TA planning policy and guidance, and monitoring policy. Put tersely, if OCD HQ is directing and advising both the regional and local levels on these matters (as it should be), it ought likewise to be leading the way in implementing such direction and advice as it gives others.

On the regional level, KAI found that considerably larger percentages of the providers sampled report regularly to the Regional Office regarding their T/TA activity: 95% of members of the RTO/STO network sampled do (see Table M86) and 70.1% of the various kinds

of regional providers interviewed also do (see Table M88). These figures tend to suggest that the Regional Offices are controlling their providers - through somewhat regular reporting at least - quite effectively and seemingly more stringently than the National Office controls the national providers.

On the local level, project staff discovered that approximately one-half of the local program people (directors, staff, parents) who were interviewed said they submitted a written report on T/TA, and that less than one-fifth of those (16.8%) said they turned one into their Regional Office (see Table M90). This tends to show that a) the local programs do not have much of an obligation to be accountable about their T/TA and b) there is probably a very small amount of direct "local program-to-regional office" accounting for T/TA activity. The reader should recall, however, that staff and parent responses have not been isolated from directors; this may result in some misleading results in that directors alone presumably are responsible for reporting.

Bi-variate analysis of those who do submit reports regarding their local program T/TA showed that they tended to be considerably more satisfied overall with T/TA received and that they tended to perceive greater impact from T/TA received--both of which are strong additional reasons for advocating consistent reporting procedures for the local programs.

Seventy-five percent of the local providers sampled said they submitted reports on the T/TA they delivered. This figure falls considerably below that for national providers (91.2%) and that for regional providers (95% RTO/STO network and 92.2% for the various kinds of regional providers sampled). Overall the local T/TA providers seem, as a result of this comparison, to be subject to less systematic reporting requirements than their national or regional counterparts.

When all three levels, national, regional, and local, are considered together, a major finding that emerges on this topic of control of providers is that nowhere is there any consistent, well-integrated system operative for the monitoring of T/TA activities. The findings on all 3 levels about reporting demonstrate tremendous

diversity in practices. In itself diversity is not bad, but no provisions seem to have been made to insure that out of such diversity can be obtained necessary reporting data in a systematic and useable format, such as would be the case with a Management Information System.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION M6 : Is an appropriate and effective evaluation system being implemented?

Just as in the previous section, M5, consideration was given to what system (reporting, monitoring, etc.) was employed by Head Start to control T/TA as it was being provided; so too, in this next section consideration will be given to what system was employed by Head Start to evaluate T/TA after it was provided.

The one system (reporting and monitoring) is appropriate during the delivery of T/TA; the other (evaluation) becomes appropriate after the fact, as a way of reviewing what was accomplished and pointing up what remains to be done. This leads back then to the beginning of the T/TA cycle repeated all over again, i.e., needs assessment, etc. In short, how Head Start evaluates its T/TA was believed by KAI staff to be still another major indicator of the overall way in which T/TA is managed.

In this section the topic of evaluation of T/TA will be addressed at the national, regional, and local levels.

a. National Level Responses

National level responses on this topic of evaluation of T/TA, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of OCD Headquarters officials and then from that of national T/TA providers.

1) OCD Headquarters Resources

To begin discussion on this subject, all Headquarters interviewees were asked about the evaluation system of the National Office. Central office staff respondents presented multifarious responses regarding evaluation processes and systems within the National Office. The largest group of responses revealed that no system--or at best, a fragmented system--existed at the National Office.

Other responses indicated that there is (or ought to be) continued movement of the evaluation responsibility to the regional and local levels. (It must be noted here that this observation runs parallel to the general central office belief that the needs assessment responsibility also should rest primarily at the local, and secondarily at the regional, levels.)

In general, the central office staff did perceive the need for systematic evaluation procedures for the totality of Head Start activities; however, the task of implementing such a system remains for future action.

Central office staff tended to see the responsibility for implementing any evaluation system as resting with a variety of offices. Some responses indicated the perception that total responsibility for evaluation rested with the OCD Planning and Analysis Division or the Research and Evaluation unit in the Children's Bureau. Still other responses indicated the perception of a fragmented primary responsibility resting with each Project Officer for the project(s) under his/her coordination. Finally, a small group recognized that evaluation seemed to be conducted by the Program Development and Innovation office--but that this office did not have total Head Start evaluation responsibility.

2) National T/TA Providers Responses

As with national office staff, national providers also were queried about evaluation of T/TA. The question asked: "Do you evaluate the training and technical assistance you provide?" The distribution of their responses appears in Table M93. Nearly all providers said they evaluated T/TA.

Table M93. Evaluation of T/TA Provided: National Providers (n=34)

Responses	Percent
Yes	94.1
No	5.9

Methods utilized for evaluation were then reported. Multiple responses were permitted. The percentages appearing in Table M94 reveal that just over half these providers used written reports by trainees. Even more reported that verbal feedback (from the trainees) either to the director or the provider were used.

Table M94. Methods Utilized for T/TA Evaluation: National Providers (n=34)

Methods	Percent Utilizing Method
1. Written reports by trainees	52.9
2. Observer/non-participant reports	20.6
3. Verbal feedback to director	61.8
4. Verbal feedback to provider	55.9
5. Other (specify)	26.5

The responses under "other" fell into two categories: the first was self-evaluation, sometimes formalized in writing, either in the final report or in a personalized evaluation form; and the second was outside evaluation, sometimes written, from either the grantee, other consultants, or from the Washington, D.C., coordinator. Ths distribution was about half-and-half for each category, and within each category, about half of the evaluations written, and the other half verbal.

Because the type of evaluation done has ramifications in regard to quality of T/TA and also affects the degree of accountability and control the national office has over its contractors, a check on the pattern of utilization was made. Half of the national providers who evaluated their T/TA used method #1 and/or #2 in combination with method #3 and/or #4, so that there was both written and verbal feedback. However, just under one-third of these providers who did evaluate their T/TA used only verbal feedback in the form of methods #3 and/or #4.

Some provider organizations consistently utilized both written and verbal evaluations, some used primarily verbal feedback. In all, it appears that, with few exceptions, there was no uniform procedure for evaluating T/TA. It tended to be rather individualized by provider organization, and within some organizations, by the particular consultant or employee.

These findings from the providers data seem to closely correspond to those reported from OCD Headquarters officials, namely, that no uniform and consistently--implemented evaluation system is in place to assess T/TA activities at the national level.

b. Regional Level Responses

Regional level responses on this topic T/TA evaluation, and all other succeeding topics in this chapter on findings, are discussed first form the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1. Regional Office Responses

These responses are further divided into two parts: an aggregated analysis of responses from all 11 regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter on findings.

a) Aggregated analysis of all 11 regions

(See Chapter II for an explanation of selection process for interviewees in the Regional Offices.)

All regional respondents (64) were asked whether they had a formal evaluation system in place in their respective Regional Offices or whether evaluation was done by any outside consultants. The answers to this question were:

Table M95. Evaluation of T/TA Received: RO Respondents

Responses	Frequency
Yes, by themselves	15
Yes, with help of consultants	5
No	5
Total	25

(n=64, many of whom did not responde)

It is noteworthy that four out of five who answered this question specified that they did in fact have an evaluation system in place. Five of the respondents indicated that they utilized outside consultants to help evaluate T/TA activities.

However, when asked to specify the manner of evaluation, the Regional Office respondents described varying processes, including such divergent approaches as evaluating via personal meetings and contacts to evaluating as part of the monitoring system. In the former approach, regional meetings, annual personnel evaluation, and evaluation by parents were mentioned; in the latter, High Impact monitoring questionaires and the Management by Objectives (MBO) system were mentioned.

In giving such varied answers, these RO respondents resemble their counterparts at OCD Headquarters.

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study" Regional Office on the subject of evaluation of T/TA. (See Chapter II for an explanation about the choosing of the "case studies.")

NEW YORK (II)

Region II personnel view the T/TA evaluation process as an area in which considerable growth can occur. The primary method of evaluation has been to distribute questionnaires to a network of contacts at the local program level. More thorough evaluative efforts are perceived to be inextricably linked to the need for additional personnel to address the evaluative and other management processes.

PHILADELPHIA (III)

There was some confusion in understanding what was meant by "formal evaluation in-house" in Region III. Two respondents indicated there is no formal in-house evaluation, but one noted that the self-assessment process regarding performance standards included a section on Regional Office perceptions.

Concerning formal evaluation by outside consultants, Drexel Institute monitors local programs.

ATLANTA (IV)

Data from this region indicates that both internal and external evaluation systems are employed. One of the processes mentioned was the Management by Objectives (MBO) system.

CHICAGO (V)

Data from Region V shows that evaluation exists through two processes. An analysis of local and provider T/TA plans plus reports about T/TA given provide the mechanism for evaluating providers. The other comes through local programs conducting self-evaluations and state T/TA committees evaluating local programs.

DALLAS (VI)

Respondents in this Regional Office said that evaluation of T/TA is conducted through forms submitted by the local grantee about T/TA provided and grantee self-assessments, which are reviewed and may prompt changes.

SEATTLE (X)

All respondents in Region X noted that in-house evaluation was done but not evaluation by outside consultants. This in-house evaluation took several forms: personnel evaluation annually, meetings with director heads, parents' evaluation, and bi-monthly meetings with local program staff and parents.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

Responses to the question as to whether a formal in-house evaluation is made shows there is some confusion as to the definition of "formal evaluation" on the part of the IMPD staff. Half answered "yes," noting the quarterly reports that come in from the CRs and the High Impact monitoring questionnaires. The other half answered "no," thereby indicating they did not view these evaluations as being "formal in-house evaluations."

Only one respondent indicated a formal evaluation done by outside consultants, notably Haskill College in Kansas.

2). Regional Provider Responses

These responses are also further divided into two parts: group one, 42 respondents from the (generally) most experienced RTO/STO/STATO/OICS network staff across the country, and group two, 77 respondents from a variety of providers: HSST/CDA, LDP, RTO/STO/STATO/OICS, and state, multi-state, or region-wide organizations, all of whom are chosen because they serve the local programs selected in our sample for on-site interviews. This format for presenting regional provider responses will be followed throughout this chapter on findings.

a) Group One: RTO/STO/STATO/OICS network responses (aggregated across all 11 regions)

Presented in this section is an analysis of the responses received from RTO/STO network personnel on the subject of needs assessment and T/TA planning. (See Chapter II for a detailed explanation on the selection process for these individuals.)

As was the case with the national providers interviewed, these regional providers were asked if they evaluated the T/TA they provided. Their responses are given here in Table M96:

Table M96. Evaluation of T/TA Provided: Regional Providers (n=42)

Responses	Percent
Yes	97.0
No	3.0

NOTE: Compare this Table with Table 94 on National Providers

These data resemble those given by the national providers, 94.1% of whom reported that they evaluate T/TA. These data indicate that more regional providers, i.e., members of the RTO/STO network, than regional officials

tend to believe that regionally-funded T/TA is evaluated: 97% of the providers vs. 80% of the RO staff who responded to the evaluation question (see Table M95).

Methods utilized for evaluation were then reported. Multiple responses were permitted. As Table M97 reveals, the most prevalent form of evaluation is a post-session written evaluation by trainees:

Table M97. Methods Utilized for T/TA Evaluation: Regional Providers (n-42)

Methods Utilized	Percent
Post-session report by trainees	78.6
Non-participant staff observation	11.9
Verbal exchange with trainees	26.2
Other	52.4

NOTE: Compare this Table with Table M94 on National Providers

The most common types of "other" evaluations were evaluations by the State Committee or Council, the grantee, the local agency, and the Head Start Director. The methods of evaluation mentioned included retrospective assessment of effectiveness, self-evaluation or evaluation by other team members, evaluation by an outside advisory group or consultant, and evaluation using a standardized survey instrument.

b) Group Two: Various regional providers' response (aggregated across seven case study regions only)

Presented in this section is an analysis of the responses received from the 77 regional providers on the subject of T/TA evaluation. (See Chapter II for an explanation of the process followed for picking these individuals.) Regional variations in these data will be highlighted as appropriate.

Evaluation of T/TA by this group of 77 regional providers was explored, first, as to whether or not each provider evaluated the T/TA he/she gave.

Table M98. Evaluation of T/TA Provided: Regional Providers (n=77)

Responses	Percent
Yes	92.2
No	6.5
Not Applicable	1.3

NOTE: This Table is a sister to Table M96 (42 Regional Providers). Compare this Table also with M93 on National Providers

Most indicated T/TA evaluation was done; this percentage (92.2%) is comparable to that for national providers (94.1%). It also compares closely with the percentage of RTO/STO network staff (97%) who evaluate T/TA.

Methods used to evaluate T/TA are shown in the following table. Multiple responses were allowed

Table M99. Methods Utilized for T/TA Evaluation: Regional Providers (n=77)

	Methods	Percent Utilizing Method
1.	Written reports by trainees	87.0
2.	Observer/non-participant reports	46.8
3.	Verbal feedback to director	76.6
4.	Verbal feedback to provider	81.8
5.	Other	26.0

NOTE: This Table is a sister to Table M97 (42 Regional Providers). Compare this Table also with M94 National Providers

Most regional providers utilized the evaluation methods written reports by trainees (87.0%) and verbal feedback to provider (81.8%). A much higher percentage of regional providers used the former method compared to national providers (87.0% vs. 52.9%). The kinds of evaluation listed under "other" fell into four categories. The first and most frequently mentioned was that an outside evaluation came from either other providers or regional office staff making visits to the programs for training or monitoring purposes. These evaluations were a mix of written and verbal. The second most frequently mentioned category was written evaluation by the director or program to the provider. The third category involved trainee and/or grantee pre- and post-T/TA evaluation. The fourth category, mentioned by only one provider, was self-evaluation.

While the items from this question are not exactly the same as those asked of the RTO/STO/STATO/OICS network providers, there does not seem to be gross inconsistency between the two groups on the one item which is very similar, reports by trainees (87.0% vs. 78.6%).

As with national providers, a check was made as to the combination of methods used. From the frequencies, it can be seen that most regional providers used both written and verbal evaluations. Overall more regional providers than national appear to utilize evaluation methods for the T/TA they provide, and they reported a higher frequency of evaluation by other people involved in the delivery of T/TA than did national. The data does not reveal anything about the content or frequency of evaluation, which would be valuable information for interpreting more precisely this whole issue. But regional providers seem to be held by a closer accountability than do national providers.

On a region-by-region basis, Table M100 shows the percent of each region's providers in our sample who utilized each method.

Table M100. Percent of Each Region's Providers Utilizing Evaluation Methods

Methods Utilized	Percent of All Regional Providers Utilizing Method	Percent of Each Region's Providers Utilizing Method						
		II (n=4)	III (n=14)	IV (n=18)	V (n=8)	VI (n=18)	X (n=9)	XI (n=10)
1. Written reports by trainees	87.0	100.0	85.7	77.8	100.0	85.7	100.0	80.0
2. Observer/non-participant reports	46.8	75.0	42.9	38.9	25.0	71.4	11.1	70.0
3. Verbal feedback to director	76.6	100.0	57.1	77.8	75.0	85.7	66.7	90.0
4. Verbal feedback to provider	81.8	100.0	64.3	77.8	87.5	85.7	88.9	90.0
5. Other	26.0	50.0	21.4	16.7	28.6	33.3	33.3	30.0

Comparing the aggregated percent of all providers utilizing each method, our "norm", included in this table from the preceding table for ease of reference, the following variances occur:

- Region II (New York) providers' usage of each method was considerably higher than the "norm";
- Region III (Philadelphia) providers' usage fell considerably below the norm for methods 3 and 4;
- Region IV (Atlanta) providers' usage was slightly lower than the "norm" for each method except number 3;
- Region V (Chicago) providers' usage exceeded the "norm" for methods number 1 and number 4, and was considerably lower for method number 2;

- Region VI (Dallas) providers' usage exceeded the "norm" for methods number 2, 3, and 4;
- Region X (Seattle) providers' usage was higher than the "norm" on methods number 1, number 4, and number 5, was considerably lower on number 2 and slightly lower on number 3;
- Region XI (UMPD) providers' usage exceeded the "norm" for methods number 2 through number 5, and was slightly lower on number 1.

The method for which particularly wide variances occurred was observer/non-participant reports. Regions II, VI, and XI evidenced high usage, whereas Regions V and, especially X, showed low usage.

c. Local Level Responses

Local level responses on this topic of evaluation of T/TA and all other topics in this chapter on findings, are discussed first from the viewpoint of Directors, staff, parents, and community leaders (when appropriate) associated with the 30 Head Start programs sampled and then from that of local level T/TA providers.

1) Local Program Responses

Project staff interviewed a total of 428 Directors, staff, and parents. (See Chapter II for an explanation of the selection process utilized.)

To begin this discussion, the Directors, staff, and parents were asked if they evaluated the T/TA received from providers. The results of that question are displayed here in Table M101, following this page.

Table M101. Evaluation of T/TA Received at Local Level
(Directors, Staff, Parents, n=428)

COUNT / ROW PCT / COL PCT / TOT PCT	REGION [illegible]	[illegible]	[illegible]	REGION V	REGION VI	REGION X	REGION XI	ROW TOTAL
YES	[illegible]	[illegible]	[illegible]	[illegible]	33	35	34	285
	[illegible]	[illegible]	[illegible]	[illegible]	12.0	12.7	12.4	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	63.5	63.6	55.7	
	[illegible]	[illegible]	[illegible]	[illegible]	7.7	8.2	7.9	
NO	[illegible]	[illegible]	[illegible]	[illegible]	16	12	[illegible]	114
	[illegible]	[illegible]	[illegible]	[illegible]	14.2	10.5	21.9	26.6
	[illegible]	[illegible]	[illegible]	[illegible]	21.8	21.8	41.0	
	[illegible]	[illegible]	[illegible]	[illegible]	3.5	2.8	5.8	
DON'T KNOW	[illegible]	[illegible]	[illegible]	[illegible]	2	4	2	19
	10.5	[illegible]	26.3	5.3	10.5	21.1	10.5	4.4
	4.2	[illegible]	7.0	1.6	3.8	7.3	3.3	
	[illegible]	[illegible]	1.2	0.2	0.5	0.9	0.5	
NOT APPL	[illegible]	[illegible]	[illegible]	4	2	4	0	20
	[illegible]	[illegible]	[illegible]	20.0	10.0	20.0	0.0	4.7
	[illegible]	[illegible]	[illegible]	6.3	3.8	7.3	0.0	
	[illegible]	[illegible]	[illegible]	0.9	0.5	0.9	0.0	
COLUMN TOTAL	48	79	71	63	52	55	61	428
	11.2	18.5	16.6	14.7	12.1	12.9	14.3	100.0

The percentage of respondents who said yes they did evaluate T/TA received was 64.3% and that percent was rather constant across regions, ranging from 55.7% among IMPD interviewees to 70.8% in Region II New York.

A second form of analysis of this data would involve the cross tabulation of these results with the data obtained on the level of satisfaction and the level of impact of T/TA received by these same respondents (see Section E 1). These cross tabluations are presented here in Table M102:

Table M102. Cross Tabulation: Satisfaction and Impact vs. Evaluation of T/TA

Satisfaction

EVALPROV	TTASATIS: VERY SATISFIED	SAT-SFIED	DISSAT-VERY DIS	ROW TOTAL
	30.1	31.1	32.1	
YES	96	136	42	273
	39.8	49.8	15.4	72.6
	81.2	67.3	73.7	
	25.3	36.2	11.2	
NO	22	66	15	103
	21.4	64.1	14.6	27.4
	18.8	32.7	26.3	
	5.9	17.6	4.0	
COLUMN TOTAL	117	202	57	376
	31.1	53.7	15.2	100.0

Impact

EVALPROV	TTAEFFCT: GREAT IDEAL	QUITE A BIT	SOME	A LITTLE NONE	ROW TOTAL
	20.1	21.1	22.1	23.1	
YES	86	91	72	23	272
	31.6	33.5	26.5	8.5	73.3
	74.1	79.1	66.0	65.7	
	23.2	24.5	19.4	6.2	
NO	30	24	33	12	99
	30.3	24.2	33.3	12.1	26.7
	25.9	20.9	31.4	34.3	
	8.1	6.5	8.9	3.2	
COLUMN TOTAL	116	115	105	35	371
	31.3	31.0	28.3	9.4	100.0

These data indicate a pattern of greater satisfaction and greater perceived impact of T/TA among those who evaluate their local program's T/TA activities. For example, 21.4% of those who do not evaluate their T/TA report being "very satisfied" with their overall T/TA, compared to 34.8% of those who do evaluate and are "very satisfied." Similarly, 54.5% of those who do not evaluate their T/TA said their T/TA impact was "a great deal" or "quite a bit," as opposed to the 65.1% of those who do evaluate that gave comparable answer.

The respondents were asked to specify what particular methods they use to carry out their evaluations. Their answers are presented here in Table M103:

Table M103. Methods Utilized for T/TA Evaluation: Local Programs (Directors, Staff, Parents, n=428)

Method	Number / Percent Utilizing	
1. Written reports by trainees	205	47.9%
2. Observe or report	81	18.9
3. Verbal Feedback to the Director	212	49.5
4. Verbal Feedback to the Provider	173	40.4
5. Other	36	8.4

The data shows more of a tendency among those interviewed to use Verbal Feedback to the Director (49.5% frequency of response), written reports by trainees (47.9%) and then verbal feedback to the provider (40.4%) as methods for conducting evaluation of T/TA than reports of observors or non-participants in T/TA activities (18.9%).

In Region IV Atlanta a considerably higher percentage of those interviewed (66.2% vs. the "norm" of 47.9%) said they use written reports turned in by trainees as a method in evaluating T/TA.

2. Local Provider Responses

As was the case with both national and regional providers, local providers were queried as to whether or not they evaluated T/TA after it was provided. Three-fourths said they did.

Table M104. Evaluation of T/TA Provided: Local Providers (n=24)

Responses	Percent
Yes	75.0
No	25.0

NOTE: Compare this Table with Table M93 (National Providers) and Tables M96 and M98 (Regional Providers)

This percent of local providers who evaluated their T/TA is lower than for regional (97% RTO/STO network; 92.2% various providers) and national (94.1%) providers.

The methods of evaluation were then probed. A majority of providers used written trainee reports and verbal feedback (from trainees) to director, as can be observed in Table M105:

Table M105. Methods Utilized for T/TA Evaluation: Local Providers (n=24)

Methods	Percent Utilizing Method
1. Written reports by trainees	62.5
2. Observer/non-participant reports	33.3
3. Verbal feedback to director	58.3
4. Verbal feedback to provider	45.8
5. Other	12.5

NOTE: Compare this Table with Table M94 (National Providers) and Tables M97 and M99 (Regional Providers)

A comparison among all types of providers is given by combining the percent utilizing each method in one table:

Table M106. Methods Utilized for T/TA Evaluation: All Providers

Methods	Percent Utilizing Method		
	National (n=34)	Regional (n=77)	Local (n=24)
1. Written reports by trainees	52.9	87.0	62.5
2. Observer/non-participant reports	20.6	46.8	33.3
3. Verbal feedback to director	61.8	76.6	58.3
4. Verbal feedback to provider	55.9	81.8	45.8
5. Other	26.5	26.0	12.5

NOTE: This Table incorporates data previously displayed in Tables M94, M99, and M103

More local providers than national used methods number one and number two. Regional providers evidenced significantly higher utilization of written reports by trainees. While it is true that we have no measure of the quality of the written reports by trainees, in terms of content, it would appear that, overall, regional providers may experience greater requirement to accountability than other providers.

On a regional basis, variances occur for every method. The table below displays the data, and for convenience, presents the percent of all local providers utilizing each method from Table M106.

Table M107. Percent of Each Region's Local Providers Utilizing Evaluation Methods

Methods	Percent of Local Providers Utilizing Method	Percent of Each Region's Local Providers Utilizing Methods			
		III (n=3)	IV (n=9)	V (n=9)	XI (n=3)
1. Written reports by trainees	62.5	100.0	44.4	55.6	100.0
2. Observer/non-participant reports	33.3	100.0	11.1	11.1	100.0
3. Verbal feedback to director	58.3	100.0	55.6	44.4	66.7
4. Verbal feedback to provider	45.8	33.3	44.4	33.3	100.0
5. Other	12.5	66.7	0.0	11.1	0.0

It can be seen that, among the local providers sampled in each region, the following patterns emerge:

- Region III providers' usage was significantly higher than the "norm" for all methods but number four;
- Region IV providers' usage was significantly lower than the "norm" for methods one, two, and five;
- Region V providers' usage was somewhat lower for all methods but number two, which was substantially lower;
- Region XI providers' usage was substantially higher methods one, two, and four, a little higher for number three, and lower for number five.

Comparing local with regional providers in each of the regions (using the differential between the "norm" for each method within each provider type and reported frequencies of use), these findings emerge. In Region III, local providers sampled showed higher usage of all methods than did regional providers. In Region IV, while both groups of providers generally fell below the particular "norm," the differential was greater for local providers. Region V's regional providers evidenced greater usage than local providers of all methods except number two, for which both groups showed comparable differential from the "norm." Region XI's local providers tended to have much higher usage of most methods than regional, but both groups were usually higher than the "norm."

Summation of M6 Findings: Evaluation of T/TA

The question addressed in this section was "is an appropriate and effective evaluation system being implemented?" Evaluation was distinguished from monitoring by virtue of its occurring after the fact.

No uniform system for evaluation T/TA exists at the national office. While some respondents believe that the evaluation responsibility for T/TA rests with the regional and local levels, which is appropriate for T/TA activities at those levels, the evaluation of nationally-funded providers emerges as a haphazard process. It is not only perceived to be the responsibility of various divisions (ranging from OCD Planning and Analysis Division or Children's Bureau Research and Evaluation unit to the particular project officer in the division most directly related to the providers; activities), but it is also in actuality implemented unevenly across the divisions and within the particular devision.

Data from the national providers parallel's the findings from the national office. Nearly all providers indicated they did evaluate their T/TA (94.1%). (See Table M93) But in terms of methods utilized for evaluation, half used both written and verbal techniques, while nearly one-third evaluated only with verbal feedback either to the program director or the provider. (See Table M94) No uniform system emerged for evaluation. The process tended to be individualized by provider organization, and even, within some organizations, by the individual consultant.

At the regional office level, four-fifths of the respondents asked about evaluation indicated that such a system was in place, either utilizing only regional office staff or outside consultants. (See Table M95) All the case study regions have some T/TA evaluation system. Variances occur from region to region, but there appears to be a rather common reliance on monitoring questionnaires and grantee self-assessments.

Regional providers as a whole evaluate their own T/TA (RTO/STO network - 97.0%; various providers - 92.2% (see Tables M96 and M98). These figures

are comparable to that for national providers (94.1%). Many more regional providers than national utilize the method "written reports by trainees (87.0% vs. 52.9%). Most regional providers use a combination of written and verbal evaluations. (See Tables M97 and M99) Generally, regional providers are subjected to evaluation from observers or non-participants in the specific T/TA session to a greater degree than national providers and appear to be held to closer accountability.

Moving finally to the local level, nearly two-thirds of the directors, staff, and parents (64.3%) evaluate the T/TA provided. The bivariate analysis employed on those data indicates that those who do evaluate manifest higher T/TA satisfaction and impact than do those who do not evaluate ("very satisfied" with the overall T/TA, 34.8% vs. 21.4%, and "a great deal" and "quite a bit" of T/TA impact, 65.1% vs 54.5%) (See Table M102)

As regards methods of evaluation, most respondents indicated utilization of verbal feedback to the director of the local program (49.5%) and written reports by trainees (47.9%). On each of these items (see Table M103), large differentials appear when a comparison is made with regional provider responses. For the method "written reports by trainees" and "verbal feedback to provider," the differential is approximately 40.0%, and for verbal feedback to the director", over 25.0%.

These findings suggest two interpretations which are not mutually exclusive. In the conduct of the regional provider interviews, the individual provider was asked to relate his/her answers to the particular local program where the on-site interviews had been conducted. However, because of the nature of some of the questions asked, regional providers had a tendency to respond in global terms covering their T/TA activities across all programs. Therefore, the differentials emerging here suggests that providers do not uniformly request or get written and/or verbal evaluation. This is particularly true as regards "written reports by trainees". Regional providers apparently get these reports on a selected basis from some programs.

Secondly, these findings may reveal an instance of inflated positive responses. It is possible that provider respondents answered that they utilize

these methods to an extent greater than happens in actuality. The dimensions of this possible inflation are unknown.

Among local providers, 75.0% evaluated the T/TA they provided. (See Table M104) (This figure compares to 92.2% of regional providers and 94.1% of national providers.) Methods of evaluation most frequently mentioned (see Table M105) were "written reports by trainees" (62.5%) and "verbal feedback to director" (58.3%). On the former method, local providers were higher than national providers (52.9%) and lower than regional providers (87.0%).

To synthesize all these data, it appears that within the national Office of Child Development, there are as many approaches to evaluating T/TA as exist across all eleven OCD regions, although the latter group has a tendency to rely on monitoring questionnaires and grantee self-assessments, whereas the former group apparently individualizes its requirement for each provider as regards evaluation processes and firms.

The majority of national, regional, and local providers, as well as local program personnel, evaluated the T/TA provided. The methods of evaluation include both written and verbal feedback, but the data suggest that, as a general rule, there is more frequent use of verbal evaluation than written.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS



MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

B. DELIVERY OF T/TA

The central question being addressed here is this -- "Is Head Start training and technical assistance being delivered effectively?". This major question has been subdivided into six topical questions to insure comprehensive and well-integrated coverage of the questions raised in the original Request for Proposal, the initial KAI response, as well as any others that arose during the conduct of this evaluation. These six topical questions are:

D 1. How satisfied are the consumers with T/TA dollars available?

D 2. How effectively are resources used in T/TA service delivery?

D 3. How effectively are other supportive resources being utilized?

D 4. How equitably is T/TA distributed among target groups?

D 5. How effectively are content areas being covered?

D 6. How effectively are special content areas, i.e., nutrition, psychological services, and handicapped needs, being addressed?

What follows now is a discussion of KAI's findings and conclusions on each of these questions. A summation will be presented at the end of each of the six sections.

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SECTION D 1. How satisfied are the consumers with T/TA dollars available?

One major indicator of how effectively T/TA is being delivered, KAI posited, was how satisfied the consumers of such T/TA were with the amount of money available for it. This line of questioning had a side benefit; it frequently gave indications as to how familiar the respondents were with T/TA funding levels and their rationale.

In this section, the topic of satisfaction of consumers with available T/TA dollars will be discussed at the national, regional, and local levels.

a. National Level (OCD Headquarters) Responses

National level responses on this topic of consumer satisfaction with T/TA dollars available come only from OCD Headquarters officials. National providers were not asked any questions on this topic. KAI project staff interviewed a total of 24 officials in OCD Headquarters in Washington, D.C. (See Chapter II for a breakdown of types and levels of officials interviewed.)

In general, central office staff are not aware of the total Head Start congressional appropriation nor of the factors that go into the determination of dollar allocation to the various Head Start units. One exception to this general finding is the fact that several respondents could identify an allocation of some 19 million dollars for T/TA activities; this common knowledge seemed directly related to the fact that this set dollar amount has remained constant for several consecutive years whereas allocations for other purposes/units have tended to increase annually.

Among the factors given by a few respondents regarding determining factors for budgetary allocation are:

- Congressional appropriation
- "Cost-of-living" increases
- New congressional mandates, i.e., "handicapped mandate" require additional funding
- Historical precedent re: dollar allocations
- Number of children served per region
- "Internal politics"

No other information was obtained from these Headquarter officials on this topic.

b. Regional Level Responses

Regional level responses on this topic of consumer satisfaction with available T/TA dollars and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers (RTO/STO network respondents only regarding this topic).

1. Regional Office Responses

These responses are further divided into two parts: an aggregated analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter on findings.

a) Aggregated analysis of all eleven regions.

(See Chapter II for an explanation of the selection process for interviewees in the Regional Offices.)

Regional Office staff were asked how satisfied they were with T/TA funding levels. As may be expected with a question involving the adequacy of funding, no one indicated that he was "Very Satisfied." However, well over a third (11 out of 27) of the respondents (only 27 of the 64 possible respondents answered this question) indicated that they were "Satisfied." Of the 16 indicating that they were "Dissatisfied", only 5 indicated they were "Very Dissatisfied," while the other 11 indicated simply that they were "Somewhat Dissatisfied."

It should be noted that, even among those who felt satisfied, there was the comment that additional money could be used and that, compared to what should really be done for T/TA, more money was needed. Another respondent indicated that though the money level was generally satisfactory, better planning was needed.

Among those indicating dissatisfaction, one respondent felt that the funding level was inadequate because HSST/CDA consumes so much of the total available money.

b) Individualized analysis of each of seven case study regions.

Presented in this section is an analysis of the collective responses of the persons in each "case study" Regional Office on the subject of consumer satisfaction with available T/TA dollars. (See Chapter II for an explanation about the process followed for choosing 'case studies.')

NEW YORK (II)

Some feeling was expressed by Region II personnel that all nationally-funded T/TA activities ought to be under the purview

of the regions with the affected dollars being redistributed on a regional basis. Presumably this regional centralized system would allow for more efficient management, tracking, monitoring, and evaluation of the T/TA efforts within the region.

PHILADELPHIA (III)

For the most part, Region III personnel appeared satisfied with the amount of dollars allocated for T/TA; one respondent reported some dissatisfaction with this funding level.

ATLANTA (IV)

As is the case in most other regions, there is some dissatisfaction with the 3.5 million dollars allocated to Region IV for T/TA purposes. Overall, there is the pervasive feeling that there is never enough T/TA service to meet the needs of all local programs.

CHICAGO (V)

The combined T/TA budget for Region V was given as $1,849,000 by regional respondents. Only one of four responded that they were "Very Dissatisfied" with this allocation of funds.

DALLAS (VI)

There is a range of feeling in this region as to the satisfaction with the amount of T/TA money available to local programs. Some people are satisfied with the amount available, while others responded that they are "Very Dissatisfied."

SEATTLE (X)

Data as to the combined T/TA allocation for Region X is not exact, with the number $701,000 as the only amount mentioned. As to how satisfied or dissatisfied respondents are with the amount of money available for T/TA to local programs, respondents in Region X are evenly split, half saying they are "Satisfied," and half saying they are "Dissatisfied."

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

No definitive data was given concerning the exact allocation of dollars to training and to technical assistance or for combined T/TA. Responding staff members divided their opinions evenly between being "Satisfied" and "Dissatisfied" with the T/TA allocation.

2. Regional Provider Responses

Presented in this section is an analysis of the responses received from RTO/STO network personnel on the subject of satisfaction with T/TA dollars available. (See Chapter II for a detailed explanation on the selection process for these individuals.)

Virtually all respondents wanted more money allocated to training and technical assistance activities throughout the various regions. However, only four of the 42 respondents believed that increased funding was necessary to produce positive change in the nature of their relationships with the National Office.

c. Local Level Responses

Project staff interviewed a total of 428 directors, staff, and parents. (See Chapter II for an explanation of the selection process utilized.) Local level responses on this topic of satisfaction with money available for T/TA came only from the directors, staff, and parents associated with the thirty Head Start programs sampled. Local providers were not asked any questions on this topic.

These respondents, by way of initiating a discussion with them on the various aspects of the delivery of T/TA to their programs, were asked how satisfied they were with the money available to them for T/TA. They were given four allowable responses: very satisfied, satisfied, dissatisfied, and very dissatisfied. The distribution of these responses when aggregated across all 7 case study regions is shown in Table D 1 on the following page.

Generally, this data shows a greater frequency of response on the negative side of the scale. Schematically this phenomenon could be pictured this way:

+ Very Satisfied	+ Satisfied	- Dissatisfied	- Very Dissatisfied	DK/NA	
6.3	28.0	29.7	17.8	14.5	3.7
34.3% (+)		vs	47.5% (-)	+ 18.2%	

The data also reveal that:

- Region II (New York) was the only one not to give a single "very satisfied" response to this question.
- Region II (New York) was the region with the smallest percentage (10.4%) of positive responses (very satisfied or satisfied) and the largest percentage (75%) of negative responses (dissatisfied or very dissatisfied)

ERIC

Table D1. Satisfaction with T/TA Money Available (DSP n=428)

CROSSTABULATION OF ENOUGHS SATISFACTION WITH AVAILABLE T&TA MONEY BY REGION REGION

ENOUGHS	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION X	REGION XI	ROW TOTAL
30. VERY SATISFIED	0	5	2	4	6	7	3	27
	0.0	18.5	7.4	14.8	22.2	25.9	11.1	6.3
	0.0	6.4	2.8	6.3	11.5	12.7	6.7	
	0.0	1.2	0.5	0.9	1.4	1.6	.7	
31. SATISFIED	5	20	14	23	23	17	10	120
	4.2	16.7	11.7	19.2	19.2	14.2	8.3	28.0
	10.4	25.6	19.7	36.5	44.2	30.9	22.2	
	1.2	4.7	3.3	5.4	5.4	4.0	2.3	
32. DISSATISFIED	22	22	20	17	10	11	17	119
	17.3	17.3	15.0	13.4	7.9	8.7	13.4	27.7
	45.8	28.2	28.2	27.0	19.2	20.0	37.8	
	5.1	5.1	4.7	4.0	2.3	2.6	4.0	
33. VERY DISSAT	14	10	19	12	4	5	1	76
	18.4	13.2	25.0	15.8	5.3	6.6	1.3	17.8
	29.2	12.8	26.8	19.0	7.7	9.1	2.2	
	3.3	2.3	4.4	2.8	0.9	1.2	.2	
88. DON'T KNOW	3	13	8	7	8	13	4	56
	5.3	23.2	14.3	12.5	14.3	23.2	7.1	13.1
	6.3	16.7	11.3	11.1	15.4	23.6	8.9	
	0.7	3.0	1.9	1.6	1.9	3.0	.9	
99. NOT APPL	4	8	6	0	1	3	1	23
	25.0	50.0	37.5	0.0	6.3	18.8	6.3	5.4
	8.3	10.3	8.5	0.0	1.9	5.0	2.2	
	0.9	1.9	1.4	0.0	0.2	0.7	.2	
COLUMN TOTAL	48	78	71	63	52	56	41	428
	11.2	18.2	16.6	14.7	12.1	13.1	9.6	100.0

- Region VI (Dallas) was the region with the largest percentage (55.7%) of positive responses and the smallest percentage (26.9%) of negative responses.

Next these respondents were asked if they had a choice in the matter, would they want more, less, or the same amount of money available to them for T/TA. The results of this question are displayed in table D 2 on the following page. The findings here are that 8 out of 10 (80.4%) of all those responding would want more money for T/TA purposes. Only 1 out of 428 respondents said less money, and 28 (6.3%) said the same.

Region II (New York) led all other regions in answering "more" (95.8%) and was the only one not to report a single "less" or "same" response.

Region X (Seattle), besides being the only region with a respondent who thought less money for T/TA would be desirable, had the smallest percentage (58.2% vs the 80.4% 'norm') of "more" responses and the largest percentage (37% vs. the 6.3% 'norm') of "same" answers.

This group of interviewees was then asked if they could get more T/TA if they wanted it. The answers to this question are presented in Table D 3. More than one-third of the 428 respondents (37.9%) said that they could get more T/TA if they wanted to. Only 24 (5.6%) said "no".

Regions X (Seattle - 49.1%), VI (Dallas - 48.1%), III (Philadelphia - 46.2%) all had an exceptionally large number of persons who answered "yes" to this question. Region II (New York), contrariwise, had the least number (14.6%) of respondents answering "yes".

Those respondents (162 total across the seven regions) who said "yes" they could get more T/TA were asked from what source, i.e., national or regional providers, non-Head Start sources, or by means of direct purchase. The responses they gave are shown in Table D 4.

ERIC

Table D2, More, Less/ or Same Money Wanted for T/TA (DSP n=428)

WANTMORE WANT MORE OR LESS MONEY — CROSSTABULATION OF WANTMORE BY REGION

WANTMORE	REGION	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	COUNT								
	ROW PCT								
	COL PCT								
	TOT PCT	2.1	4.1	3.1	5.1	6.1	10.1	11.1	
5. MORE		48	58	63	53	46	32	30	330
		14.5	16.9	18.3	15.4	13.4	9.3	8.7	100.0
		96.0	74.4	88.7	84.1	76.7	94.1	83.3	
		10.7	13.6	14.7	12.4	9.3	7.5	7.0	
6. LESS		0	0	0	0	0	1	0	1
		0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.2
		0.0	0.0	0.0	0.0	0.0	2.9	0.0	
		0.0	0.0	0.0	0.0	0.0	0.2	0.0	
7. SAME		0	2	2	9	6	0	2	21
		0.0	9.5	9.5	42.9	28.6	0.0	9.5	4.9
		0.0	2.6	2.8	7.9	11.5	0.0	5.6	
		0.0	0.5	0.5	2.1	1.4	0.0	0.5	
8. DON'T KNOW		2	9	6	4	4	0	4	29
		6.9	31.0	20.7	13.8	13.8	0.0	13.8	6.8
		4.2	11.5	8.5	3.8	7.7	0.0	11.1	
		0.5	2.1	1.4	0.9	0.9	0.0	0.9	
9. NOT APPL.		0	9	0	1	2	0	0	12
		0.0	75.0	0.0	8.3	16.7	0.0	0.0	2.8
		0.0	11.5	0.0	1.9	3.8	0.0	0.0	
		0.0	2.1	0.0	0.2	0.5	0.0	0.0	
COLUMN TOTAL		48	78	71	53	52	33	36	426
		11.3	18.3	16.7	12.4	12.2	7.7	8.5	100.0

ERIC

KIRSCHNER ASSOCIATES INC.

Table D3: Availability of Additional T/TA (DSP n= 428)

CROSSTABULATION OF GETMORE BY REGION

GETMORE COULD GET MORE T&TA IF WANTED

GETMORE	REGION	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION X	REGION XI	ROW TOTAL
YES	1.	7	16	25	19	[illegible]	27	[illegible]	152
		4.6	22.2	14.2	11.7	15.4	16.7	15.4	17.9
		14.6	46.2	52.4	39.2	48.1	49.1	41.5	
		1.6	8.4	5.8	4.4	5.8	6.3	5.8	
NO	2.	6	3	6	5	2	3	[illegible]	24
		25.0	12.5	33.3	20.8	8.3	12.5	8.3	5.6
		12.5	3.8	11.3	8.0	3.8	3.5	3.3	
		1.4	0.7	1.9	0.9	0.5	0.7	0.5	
HOPE SO	3.	18	13	10	27	5	6	10	89
		21.2	14.6	11.2	30.3	5.6	6.7	11.2	20.6
		37.5	16.7	14.1	42.9	9.6	10.9	19.4	
		4.2	3.0	2.3	6.3	1.2	1.4	2.3	
LOOKING	4.	4	2	3	2	1	0	[illegible]	12
		33.3	16.7	25.0	16.7	8.3	0.0	0.0	2.8
		8.3	2.6	4.2	3.2	1.9	0.0	[illegible]	
		0.9	0.5	0.7	0.5	0.2	0.0	[illegible]	
DON'T KNOW	8.	8	21	27	15	19	17	[illegible]	131
		6.1	16.0	20.6	11.5	14.5	13.0	15.3	30.6
		16.7	26.9	38.0	[illegible]	36.5	31.9	30.3	
		1.9	4.9	6.5	[illegible]	4.4	4.0	[illegible]	
NOT APPL	9.	5	3	0	2	0	2	0	10
		50.0	30.0	0.0	0.0	0.0	20.0	0.0	2.3
		10.4	3.8	0.0	[illegible]	0.0	3.6	0.0	
		1.2	0.7	0.0	0.5	0.0	0.5	[illegible]	
COLUMN		48	78	71	63	52	56	[illegible]	428

TABLE D 4. Sources for Additional T/TA
(across 7 case study regions)
(Directors, Staff, Parents n=162)

SOURCE	#/% YES	#/% NO
National Providers	45/10.5%	383/89.5%
Regional Providers	104/24.3%	324/75.7%
Non-Head Start	86/20.1%	342/79.9%
Direct Purchase	62/14.5%	366/85.5%

Approximately one in four (24.3%) replied that more T/TA could be gotten from regional providers. Next, in order of frequency of response, came non-Head Start sources (20.1%), direct-purchase of T/TA (14.5%), and national providers (10.5%).

Region VI (Dallas) had the largest percentage of interviewees who said they could obtain more T/TA from regional providers - 38.5% vs. the 'norm' of 24.3%.

Conversely, Region V (Chicago) had the smallest percentage of respondents who felt they could get more T/TA from regional providers - 9.5% vs. 24.3% ('norm').

The 'normal' frequency of response, taking all 7 case study regions as an aggregate, to the question about being able to get more T/TA through direct-purchase was 14.5% affirmative vs. 85.5% negative. Two regions exceeded this 'norm' considerably: XI (IMPD - 26.2% affirmative), and V (Chicago - 25.4% affirmative). At the same time, two regions fell below this 'norm' considerably: IV (Atlanta - 4.2% affirmative) and X (Seattle - 5.5% affirmative).

Summation of DI Findings: Satisfaction with T/TA $

The question asked in this section was "how satisfied are the consumers with T/TA dollars available?"

Generally more than half of the interviewees in any category of respondent answering this question reported being dissatisfied with the amount of T/TA dollars available for example, 16 RO respondents answered this way, as opposed to 11 who were satisfied; and 47.5% of the directors, staff, and parents who responded said they were dissatisfied, vs. 34.3% who were satisfied. This phenomenon is very difficult to draw conclusions from. It may imply people are not satisfied with their currently available T/TA dollars and are upset about it. It might also indicate a generally positive feeling about the way T/TA dollars are spent and a hope that more dollars could be allocated to extend the program.

Other data seems to support the latter suggestion : 8 out of 10 local interviewees said they'd rather have more T/TA money, as opposed to less or the same. More than one-third of these same respondents said they could obtain more T/TA if they wanted it (See Table D3). The two potential sources most frequently mentioned were regional providers and non-Head Start resources.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION 02.. How effectively are resources used in T/TA service delivery?

KAI staff believed that another major indicator of how effectively T/TA is being delivered was how Head Start was utilizing the resources available. This question actually must be broken down in two ways, because it is one thing to ask Head Start staff what T/TA resources they use (i.e., which kind of provider, etc.) and quite another to ask the providers what resources they use (e.g., distribution of time formulas, etc.)

Specifically, in this section, when the interviewees are program people the questions relate to what type of providers are utilized as resources (e.g., university vs. private firm or national provider vs. local provider, etc.) and to what extent are they used. Also, a small piece is presented (with RO responses only) on what kinds of delivery-settings are utilized, to what extent, and how successfully.

When the interviewees are providers, the focus of the question is, by virtue of their role, quite different. For example, providers at all levels (national, regional, and local) are queried about whether or not they devise and follow a formula for the use of their time, a formula for when and for what purpose they visit their client (i.e., the national or regional office or the local program), and whether or not they pursue any skill development activities. They are also asked about which kinds of T/TA they deliver most often. All of these questions are designed to elicit information on what the providers themselves do and, by extension, what resources Head Start officials and staff have at their disposal in the delivery of T/TA.

In this section, the topic of T/TA resources utilized will be discussed at the national, regional, and local levels.

a. National Level (Provider) Responses

No data was collected on this topic from OCD Headquarters officials. However, a number of questions relating to the topic were put to the national providers.

One of the resources available to providers that will have an impact on how they deliver T/TA is time and how well they manage it. In an effort to develop an indication of how providers utilize their time, each was asked, "do you attempt to distribute your time according to any set formula, e.g., 30% to coordinating T/TA activities, 30% to providing consulting help directly to the locals, 20% providing training to Head Start Grantees and 20% to administrative tasks?" National providers responded:

Table D5. Distribution of Time to a Set Formula: National Providers (n=34)

Responses	Percent
Yes	38.2
No	47.1
Not Applicable	14.7

Just under 40% indicated they did attempt to distribute their time according to a formula. When asked to explain what the formula was, their answers were categorized into the following distributions:

Table D6. Formulas by Which National Providers Distribute Their Time (n=13)

Formulas	Percent Utilizing Formula
100% Administration	15.4
100% T/TA	--
50% T/TA; 50% Administration	23.1
40% T/TA; 60% Administration	23.1
80% T/TA; 20% Administration	7.7
70% T/TA; 30% Administration	7.7
30% T/TA; 70% Administration	23.1
Other	--

By way of explaining the categorization procedure, administrative activities included planning and coordination of T/TA delivery, as well as the paperwork that necessarily accompanies such activities. T/TA activities were defined as those T/TA services actually delivered in the field, on-site, and consulting, whether via phone or in person.

The table shows that of the 13 national providers who attempted to plan their time according to a formula, slightly less than 40% spent half or more of their time delivering T/TA (50%, 70%, 80%, and 100% T/TA categories totaled). More than 45% of the providers spent 40% or less time in actual delivery of services. The remaining 15% spent all their time in administrative tasks. So those providers who tried to spend 50% or more of their time delivering T/TA were in a minority. It should be mentioned that we are referring here only to those who indicated they did have some formula; other who did not may in fact also spend 50% or more of their time in the field.

To get another measure of the nature of T/TA activities conducted by providers, KAI staff asked national providers, "On what basis do you determine when and for what purpose to visit (the Regional Office) (the local grantee/center)?" Their responses appear below in Table D7:

Table D7. Basis for National Providers' Visits to Regional Office and/or Local Grantee (n=34)

Basis for Visiting Regional Office and/or Local Grantee	Percent*
At their request	61.8
Routinely (based on T/TA plan)	38.2
National Office recommendation	32.4
Regional Office recommendation	32.4
Crisis intervention	38.2
Other	5.9

*Multiple responses allowed.

A majority of national providers said they visited at the request of the Regional Office or local grantee. Just under 40% indicated their visits were routine based on the T/TA plan. An equal number visit for crisis intervention. ("Other" included visits for planning workshops and needs assessment on-site.) These responses indicate generally that there is a high degree of flexibility in the timing and purpose of visits to both regional offices and local grantees by national providers.

The relatively low percent visiting on the basis of the T/TA plan (38.2%) places new light on the earlier findings about the percent of national providers who prepared a T/TA plan or work statement (64.7% - see Table M9). It is apparent that the T/TA plans did not, as a general rule, include provisions for routine or regular visitation. While flexibility to visit either the Regional Office or local grantees when needed is a plus, the apparent lack of on-going as well as follow-up T/TA in a planned fashion by the majority of national providers sampled is not. For the regional offices and local programs to maximize national T/TA providers, there must be known and fairly continuous level of service available. It seems that, among our sample, services tended to be given in a more sporadic way than integrated planning by national and regional offices would have permitted.

Next, the topic of T/TA content was addressed. National providers were asked to name the three categories of T/TA each most frequently offered in Fiscal Year 1974 and in Fiscal Year 1975. Table D8, following this page, presents the data. But first an explanation of the figures is necessary. Among the 34 national providers interviewed, five said that answering the question about T/TA categories for FY 1974 was not applicable. The reasons were either that the individual had not worked for the organization in FY 1974 or that the organization's activities could not be categorized in that fashion (e.g., ERIC). For FY 1975, 18 respondents said not applicable. These respondents were primarily from organizations which did not have FY 1975 contracts (American Psychological Association, American Dietetic Association, Technical Assistance Develop-

ment Systems, High Scope), although ERIC respondents were also represented here. In order to make more comparable calculations, the percentages given in Table D8 are based on the number of respondents who named categories, excluding not applicable responses.

Table D8. Categories and Rank Order of T/TA Most Frequently Offered by National Providers in Fiscal Years 1974 and 1975

Categories of T/TA	Fiscal Year 1974		Fiscal Year 1975	
	(n=29)	Rank Order	(n=16)	Rank Order
Education	55.2	1	50.0	1
Parent Involvement	20.7	5	43.8	2
Social Services	6.9	8	12.5	5
Health	24.1	4	43.8	2
Medical	6.9	8	12.5	5
Dental	10.3	7	25.0	4
Mental	17.2	6	--	-
Nutrition	20.7	5	12.5	5
Handicapped	27.6	3	12.5	5
Needs Assessment	27.6	3	12.5	5
Administration	24.1	4	31.3	3
Management Skills	10.3	7	6.3	6
Fiscal Management	3.4	9	6.3	6
Record-Keeping	--	-	6.3	6
Performance Standards	31.0	2	6.3	6
Other	10.3	7	12.5	5

The majority of national providers in both fiscal years (FY74 - 55.2%, FY 75 - 50.0%) named education as the most frequently offered T/TA component. For FY 1974, the category mentioned with the next highest frequency was performance standards (31.0%). The drop in frequency between this and education T/TA was almost 25.0%. Both handicapped and needs assessment ranked third in FY 1974 (27.6%). Second in FY 1975 were health and parent involvement (each 43.8%) and third, administration (31.3%) T/TA. The shift in second and third most frequently offered T/TA occurring between FY 1974 and FY 1975 is a function primarily of the types of providers in our sample, i.e., handicapped, nutrition, and mental health providers, strongly represented in FY 1974 and not in FY 1975. A perusal of the table suggests that parent involvement is closely linked with health T/TA, and because of the mix of providers responding for FY 1975, these two categories rose to greater ascendency in FY 1975.

Three other items are of interest. One is the consistently high frequency (relatively speaking) of administration T/TA. This need appears to be a constant. The other two are needs assessment and performance standards T/TA, which showed a marked decline in frequency for FY 1975.

From the topic of categories of T/TA offered, KAI interviewers moved to a discussion of skill development activities in which national providers participate. National providers were queried, "Do you participate at least once a year in any of the following activities to increase your skill and

expertise?" Their responses were distributed across the activities as follows:

Table D9. Participation in Skill Development Activities: National Providers (n=34)

Skill Development Activities	Percent of National Providers Participating
Attend refresher courses/seminars/ conferences	88.2
Read current literature in particular field	94.1
Collect new audio-visual materials	79.4
Collect new kits/packets	79.4
Subject self to evaluation from trainees	82.4
Other	2.9

NOTE: There was another item in this listing which was supposed to read, "Subject self to evaluation from other trainers." Unfortunately, a typographical error which made "trainers" appear as "trainees" was not caught in the proofing process, and we have omitted this item from analytical consideration.

As can be seen, a vast majority of national providers indicated participating in all these activities. The greatest percentage read current literature in their particular field of expertise (94.1%). The areas that the least percentage of providers were able to utilize for developing skills occurred in the collection of materials. This may be a function partly of availability of useful materials. There is a natural tendency to answer this entire question in the positive, so the reader should be aware of the possibility of inflated percentages appearing in this range of items.

b. Regional Level Responses

Regional level responses on this topic of T/TA resources utilized, and all other succeeding topics in this chapter on findings, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1. Regional Office Responses

These responses are further divided into two parts: an aggregated analysis of responses from all 11 regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter on findings.

a) Aggregated analysis of all 11 regions

(See Chapter II for an explanation of the selection process for interviewees in the Regional Offices.)

Regional Office respondents were asked to list the agencies/organizations which provide T/TA services to programs in their regions. Their responses were as follows:

Table D10. T/TA Organizations Utilized (Type): RO Respondents

Response	Frequency
University/College	6
Head Start Staff (RTO/STO)	5
Consultants	5
Non-Profit Corporation	3
National Agencies	1
State Agencies	2
Local Agencies	1

(n-64, many of whom did not respond)

T/TA activities were provided in three delivery-setting varieties;

- Inter-program site visists
- On-site convenings
- Off-site convenings

The reported frequency of use of the three delivery-settings is summarized as follows:

Table D11. T/TA Delivery-Settings Utilized (by Type): RO Respondents

Responses	Frequency		
	Inter-Program Site Visits	On-Site	Off-Site
University/College	3	6	7
RTO/STO	2	3	5
Other Head Start Staff	1	1	2
Consultants	-	2	2
Non-Profit Corporation	1	4	4
Agencies (national, state, local)	1	1	1

(n=64, some of whom did not respond; multiple answers were allowed)

A summary of ratings on the effectiveness of the three settings in the delivery of T/TA is given below:

Table D12. Effectiveness of Three T/TA Delivery-Settings: RO Respondents

	Excellent	Very Good	Good	Fair	Poor
Inter-Program Site Visits		8			
On-Site	4	11	5	1	
Off-Site		8	4	1	1

(n-64, many of whom did not respond)

Inquiry was then made about whether any request for T/TA service had had been denied by any national provider, 21 respondents said "No," and and only one said that a request had gone unanswered. A discussion on RO respondents comments regarding specific national providers in presented in a later section on "Excellence of T/TA."

b) Individualized analysis of each of seven case study regions

Project staff selected seven regions for purposes of intensive "case study." (See Section II for an explanation of this selection process).

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study" Regional Office on the subject of T/TA resources utilized. (See Chapter II for an explanation about the selection of the case studies.)

NEW YORK (II)

Throughout Region II the primary means employed to provide T/TA services were:

- Seminars, usually 2-3 days, on-site and off-site
- Use of video-taped presentations
- On-site consultant training, usually on a one-to-one basis
- Visits between and among various local program staff.

All of these means were rated "Very Good" to "Excellent" by Region II staff.

PHILADELPHIA (III)

The only organizations/agencies that were named as providing direct T/TA to programs in Region III were the universities and colleges. They were rated as providing a great deal of T/TA, although it was noted that, as contractors, they were not supervised by the Regional Office staff. The STOs were, in fact, employees of the universities, and therefore they as contractors were very independent.

In examining which setting T/TA is best delivered, Region III data shows strongest support for on-site convenings. The effectiveness of this setting as used by the university providers and STOs in Region III was rated as "Very Good" to "Excellent."

The second choice of setting is off-site convenings. These are seen as particularly necessary when a new program starts, and the effectiveness was rated as "Very Good."

Inter-program site visits was the third choice of setting for delivery of T/TA and was seen as being effective in certain situations.

Region III receives assistance from the AAP in the form of consulting services to local programs two or three times a year. Also, they provide the health liaison person re T/TA. The assistance from the AAP was rated as "Good," although the comment was made that there were mixed reactions concerning AAP currently coming from the field.

The U.S. Public Health Service was noted as providing excellent dental help to Region III programs. Also, CDA, HSST and ERIC were mentioned as beginning to provide assistance but they were difficult to rate since these contracts were just starting.

Region III reported no instance in which T/TA service was requested from a national provider which was not honored by the provider.

Several suggestions were offered to improve the service given by national providers, such as more accessibility of trainers. Regarding the AAP, it was suggested they should have more knowledge of the plans for health activities by the health liaison specialist in Region III.

It was also foot-noted that there was no conviction that national providers were very effective on the local program level.

ATLANTA (IV)

Region IV's providers were drawn primarily from universities and colleges, and secondarily from non-profit corporations. T/TA activities have been carried out mostly on-site at the local level, in some off-site centers (usually associated with university/college providers), and through a limited number of inter-program site visits. For FY 75

the region decided to put greater emphasis on the provision of T/TA services to clustered groupings of local program personnel.

The aggregate viewpoint of relevant Region IV personnel is that the total T/TA activities merited ratings in the "Excellent," and "Very Good" categories. Of the activities in the three different settings, the on-site T/TA offerings were regarded to be the most effective ("Excellent"); off-site convenings and inter-program site visits were rated as "Very Good."

Specific T/TA offerings were given in Region IV on the following subject/technique areas:

- Management
- Record Keeping
- Budget
- Needs Assessment
- Health
- Parent Involvement
- Education
- Community Services
- Performance Standards
- Classroom Activities
- Training Packages
- Audio-Visual Materials
- Construction and Use

Approximately 70% of these specific activities were rated as "Excellent" and/or "Very Good"; the remaining 30% were rated as "Good." No T/TA activity was rated in the "Fair-Poor" categories.

In addition, Region IV received T/TA service from several national provider sources. The American Academy of Pediatrics provided a

pediatric nurse and another registered nurse on a full-time basis; the T/TA service provided by this AAP source was regarded to be "Excellent."

National provider assistance in dental services was received from the U.S. Public Health Service; it, too, was rated as "Excellent" by Region IV personnel.

Finally, the region received several consultative conferences from University Research Corporation; these services were rated in the "Very Good" category.

No requested service has been denied by any national provider. Regional interviewees did not perceive any changes needed to improve the process of securing service from national providers.

CHICAGO (V)

It is the response in Region V that there is no way to break down the providers into types and techniques used. State agencies have staff people who work with state providers and/or local programs. Often this T/TA is provided free although they are occasionally hired as consultants.

The effectiveness of inter-program site visits is rated as "Very Good" but not very many programs do it due to a limitation of time. On-site convenings were rated as "Very Good," and off-site cluster convenings are "Good" if based on a level of common need where Head Start programs can share their concerns in a group setting.

Various national providers provide services in Region V, such as the APA which was very effective, the AAP, the ADA, the U.S. Public Health Service and TADS.

There is no data as to whether T/TA was requested from national providers but not received.

Region V provided no suggestions for improvements in the service given by national providers.

DALLAS (VI)

Very limited responses from Region VI indicated only that universities and colleges as well as Head Start RTO and STO staff provided direct T/TA to programs in Region VI. Universities/colleges and agencies all delivered T/TA in all three settings: inter-program site visits; on-site; and off-site convenings, which were noted to be cluster workshops.

The effectiveness of the inter-program site visits and the on-site convenings was rated as "Very Good," while the cluster workshops in off-site convenings was given a "Good" to "Fair" rating.

In the national provider group, the AAP was noted for its assistance through a health liaison and pediatric consultant to the local programs, and the American Dietetic Association and American Psychiatric Association were also mentioned. All of these national providers were given "Excellent" ratings, but it was noted that the rating was a judgment of the actual person who delivered the assistance, not necessarily the provider in general.

As far as the Regional Office is concerned, the national providers work as contractors for the Regional Office and under their jurisdiction, and therefore they get excellent services.

Region VI staff perceived the need for some improvement in the national provider processes for delivery of T/TA service. Services given by national providers should be consolidated to avoid duplication which proves to be wasteful. The Regional Office should have input as to how the services will be provided before the contracts are let. There is also a feeling that consultants chosen should have a strong interest in children, not just an expertise in their field.

SEATTLE (X)

Scant data was returned in answer to the question which agencies provide direct T/TA to programs and how much. Regional Office program analysts were mentioned as giving a great deal of technical assistance, and STATOs were cited with some frequency as giving a great deal of training to programs in Region X.

The STATO in Region X used inter-program site visits (informal), on-site convenings and off-site convenings for settings in which to deliver T/TA. Program analysts also made use of on-site and off-site convenings. All these were rated as "Very Good" by the 3 of 6 respondents who answered. It was noted by one respondent that off-site convenings were best for Policy Council or Board people because 1) they get to know each other better and 2) distractions are avoided.

Most respondents credited the AAP with providing "Very Good" to "Excellent" assistance to their programs in Region X. The U.S. Public Health Service also received a "Very Good" to "Excellent" rating, with one respondent terming U.S. Public Health assistance as "phenomenal."

All respondents said they had never requested T/TA from national providers and not received it, but one noted they had written Headquarters regarding bad service by a contractor who was supposed to provide information on handicapped and never adequately did so.

Most respondents felt no improvements were needed in service given by national providers. One, however, commented that the assistance offered by national providers could be more timely.

INDIAN AND MIGRANT PROGRAM DEVELOPMENT (IMPD)

Universities and colleges were mentioned by several respondents as providing quite a bit of direct T/TA to programs in the IMPD region. Several non-profit corporations, such as the Native American Technical Assistance Corporation and the Southwest Educational Lab for migrants in Austin, Texas, were also named and credited with giving "Quite a Bit" of T/TA.

Other direct providers mentioned in the IMPD region were OICS and MEDC and six tribal composites in Arizona, New Mexico, Montana, the Dakotas, and Minnesota.

Inquiry was made as to the types of setting in which T/TA was delivered and the effectiveness of each.

The interest in the IMPD region was strongest for on-site convenings. It was felt that this was the best approach for most providers, and that the grantees wanted this.

Inter-program site visits, with good planning, received some interest and there was indication that more T/TA in this setting was desirable.

There were conflicting feelings concerning off-site convenings for delivery of T/TA. It was rated as "Good" when interpreted to mean an off-site gathering to explain directives and mandates, but was given a "Very Poor" rating when seen as large gatherings of program people who accomplish nothing.

Among national providers, the AAP was mentioned most often as providing several health specialists plus a secretary. There was a difference in feeling as to how effective these services were, with support in the "Very Good" to "Good" range but some ratings, based on feedback from the field, of only "Fair" services.

Another national provider mentioned was the U.S. Public Health Service which provides dental and medical services at the grantee level and was rated on a range from "Good" to "Poor."

Other national providers were mentioned briefly as giving services to IMPD but on which there is not enough data to rate. These are the AMA, the APA, the ADD, Social Dynamics and Littlejohn.

Scant data indicates that there were no situations in which T/TA was requested from a national provider and not received.

There is an indication that greater coordination between the national providers and the IMPD staff would lead to improved services from the national providers. There is some confusion as to which national organization specialities will fill what IMPD needs.

Specifically, a suggestion was made that the AAP, as an organization, should take a more active role in translating OCD thrusts so that all their people delivering services out in the field understand their objectives.

2) Regional Provider Responses

These resources are also further divided into two parts: group one, 42 respondents from the (generally) most experienced RTO/STO/STATO/OICS network staff across the country, and group two, 77 respondents from a variety of providers: HSST/CDA, LDP, RTO/STO/STATO/OICS, and state, multi-state, or region-wide organization, all of whom were chosen because they serve the local programs selected in our sample for on-site interviews. This format for presenting regional provider responses will be followed throughout this chapter on findings.

a) Group One: RTO/STO/STATO/OICS network responses (aggregated across all 11 regions)

Presented in this section is an analysis of the responses received from RTO/STO network personnel on the subject of T/TA resources utilized. (See Chapter II for a detailed explanation on the selection process for these individuals.)

Inquiry was made as to a method or allocation strategy for the use of the professional time by RTO/STO/STATO/OICS. Slightly more than half of the 39 training officers who responded to the question indicated that they did <u>not</u> distribute their time according to any set formula.

A few cited reasons or explanations of their <u>use of time</u>, such as:

- first-come, first-serve
- more to larger, less to smaller
- priority based
- 95% coordination

Those training officers who did distribute their time according to formula (18 respondents) cited a variety of formulas, which included explicit budgeted percentages, such as:

- 50% T/TA; 50% Administration;
- 70% T/TA; 30% Administration;
- 30% T/TA; 70% Administration; or
- 80% T/TA; 20% Administration.

Other respondents discussed the rationale for their distribution of time without specifically noting their "formula," e.g.:

- by designated man-days;
- not by percent of time, but by scheduling a visit to each program quarterly; or
- by state requirements.

Data was also sought from RTO/STO/STATO/OICS on the nature and kinds of skill development activities in which they themselves participate specifically to increase their own knowledge and skill.

The overwhelming majority of training officers make use of a variety of self-improvement techniques. Differences in amounts of use among techniques is not significant, as is shown below:

Table D13. Participation in Skill Development Activities: RTO/STO Network

Activity	Number Responses	Percent of 42
Attend refresher courses	37	88%
Read current literature	38	91%
Collect audio-visual	38	91%
Collect kits/packets	37	88%
Evaluation from trainees	38	91%
Evaluation from trainers	36	86%
Other	2	5%

(n=42; a few of whom did not respond)

NOTE: Compare this Table with Table D9 on National Providers

"Other" activities mentioned included attending workshops and university attendance.

b) Group Two: Various Regional Provider Responses (aggregate across seven case study regions only)

Presented in this section is an analysis of the responses received from the 77 regional providers on the subject of T/TA resources utilized. (see Chapter II for an explanation of the selection process for these individuals.) Regional variations in these data will be highlighted as appropriate.

As was mentioned for national providers, the time available to providers to arrange for and/or provide services is an issue in the delivery of T/TA. In an effort to develop an indication of how regional providers utilize their time, each was asked, "Do you attempt to distribute your time according to any set formula, e.g., 30% to coordinating T/TA activities, 30% to providing consulting help directly to the locals, 20% providing training to Head Start Grantees, and 20% to administrative tasks?" Regional providers answered:

Table D14. Distribution of Time to a Set Formula: Regional Providers (n=77)

Responses	Percent
Yes	53.2
No	46.8

NOTE: Compare this Table with Table D5 on National Providers

Over half of the regional providers indicated they did attempt to use some kind of formula to distribute their time. This figure is higher than for national providers (38.2%). Of the total number of regional respondents who did use a formula (41 respondents), 10 were from Region III (Philadelphia) and 10 from Region VI (Dallas). These two regions accounted for half the total.

Then each provider who answered "Yes" (41) explained what his/her particular formula was. Table D15 presents the types of formulas offered.

Table D15. Formulas by Which Regional Providers Distribute Their Time (n=41)

Formulas	Percent
100% Administration	9.7
100% T/TA	2.4
50% T/TA; 50% Administration	19.5
40% T/TA; 60% Administration	7.3
80% T/TA; 20% Administration	12.2
70% T/TA; 30% Administration	19.5
30% T/TA; 70% Administration	7.3
Other	22.0

NOTE: Compare this Table with Table D6 on National Providers

Looking at just those providers who spent 50% to 100% of their time in actual provision of T/TA, the figures total 51.2%. Slightly under 15% spent less than 50% of their time on actual T/TA. Nearly one-quarter specified responses that had to be classified as "other" (according to MBO mandate, according to Regional Office stipulation, and as needs arise). Those providers devoted exclusively to administrative tasks (planning and coordinating T/TA) comprised almost one-tenth.

The providers who attempted to spend 50% of more of their time in the field and over the phone delivering training and technical assistance were in the majority. This total represents about a 15% increase over national providers. A cautionary note must be sounded, however because these figures speak only of those who indicated they did have some formula. The others who did not may include a number who spend half or more of their time on-site and consulting.

As a further indication of the factors that must be considered in T/TA delivery, regional providers were asked to indicate the bases for determining when and for what purposes to visit the Regional Office or local grantee. Table D16 presents their responses:

Table D16. Basis for Regional Providers' Visits to Regional Office and/or Local Grantee (n=77)

Basis for Visiting Local Grantee	Percent*
At their request	92.2
Routinely (based on T/TA plan)	68.8
National Office recommendation	22.1
Regional Office recommendation	64.9
Crisis intervention	64.9
Other	13.0

*Multiple response allowed.

NOTE: Compare this Table with Table D7 on National Providers

Nearly all respondents said that one of the bases for their visits was the local grantee's request. Almost 70% visit routinely, based on the T/TA plan. Crisis intervention and Regional Office recommendation were each mentioned by about two-thirds of the respondents. Responses in the other category fell into two types: monitoring or evaluation visits (pre-review, assessment, certification), mentioned by most providers, and training visits.

The regional providers evidence a much higher level of requirement to visit based on the T/TA plan (68.8%) (see Table M32) than do national providers (38.2%). This factor permits more continuity of T/TA services and speaks pointedly to the difference between the regional offices' requirement for planning T/TA services delivery and accountability of providers and that of the national office. It is true, however, that, similarly to national providers, a lower percent of regional providers visited routinely, based on the plan, than did write a T/TA plan, which presumedly would include some type of scheduling requirements (68.8% vs. 92.2%). (The figures for national providers were 38.2% visiting on the basis of the T/TA plan vs. 64.7% writing a T/TA plan.) Although the differential between these two figures (visit vs. write T/TA plan) is similar for regional and national providers, the data supports the fact that most regional providers were under stricter planning requirements than national providers. At the same time, regional providers evidence a high degree of responsiveness to visiting upon request (92.2%).

Regional variations were found on each of these items except "at their request" and are summarized as follows:

- Compared to the "norm" of 68.8% who visited local grantees on the basis of the T/TA plan, Region II (New York) providers were low (50.0%) as were Region X (Seattle) providers (44.4%). However, Region XI (IMPD) providers were high (90.0%);
- Compared to the "norm" of 22.1% who visited local grantees on the basis of national office recommmendation, Region II (New York) and Region XI (IMPD) providers were high (50.0% each), and Region V (Chicago) and Region X (Seattle) providers low (0.0%);
- Compared to the "norm" of 63.6% who visited local grantees based on regional office recommendation, Region II (New York) and Region III (Philadelphia) providers were high (100.0% and 78.6%) respectively), and Region V (Chicago) and Region VI (Dallas) providers were low (50.0% each);

- Compared to the "norm" of 64.9% who visited local grantees based on crisis intervention, Region XI (IMPD) and Region IV (Atlanta) providers were high (100.0%, and 77.8% respectively) and Region II (New York) Region VI (Dallas), and Region X (Seattle) providers low (50.0%, 42.9%, and 33.3% respectively);
- Compared to the "norm" of 14.3% who visited on an "other" basis, Region II (New York), Region V (Chicago), and Region XI (IMPD) providers were low (0.0% each).

From questions relating to time distribution and bases for visiting local grantees, we moved to the topic of T/TA content. Regional providers were asked to name the three categories of T/TA and most frequently offered in Fiscal Years 1974 and 1975. Before discussing the data, one point must be explained. We sampled 77 regional providers, and of these, five answered not applicable for FY 1974, and two for FY 1975. The reasons for this answer were either that the individual was new enough to the provider organization that he/she was not involved in FY 1974, or that the funding cycle was such that, at the time of the interviewing, the provider was still contracted out of FY 1974 monies. In order to make comparable calculations between the two years, the percents listed are based only on the number who names categories, excluding not applicable responses. Table D17 follows this page.

Table D17. Categories and Rank Order of T/TA Most Frequently Offered by Regional Providers in Fiscal Years 1974 and 1975

Categories of T/TA	Fiscal Year 1974		Fiscal Year 1975	
	Percent (n=72)	Rank Order	Percent (n=75)	Rank Order
Education	52.8	1	50.7	1
Parent Involvement	37.5	2	37.3	3
Social Services	9.7	7	4.0	12
Health	9.7	7	12.0	8
Medical	--	--	1.3	--
Dental	1.4	10	--	--
Mental	1.4	10	1.3	14
Nutrition	6.9	8	6.7	10
Handicapped	31.9	4	41.3	2
Needs Assessment	16.7	7	20.0	6
Administration	27.8	5	24.0	5
Management Skills	18.1	6	14.7	7
Fiscal Management	6.9	8	8.0	9
Record-Keeping	1.4	10	2.7	13
Performance Standards	36.1	3	34.7	4
Career Development	2.8	9	4.0	12
All or most of above*	9.7	7	6.7	10
Other	1.4	10	5.3	11

NOTE: Compare this Table with Table D8 on National Providers

* Because some provider respondents answered that the T/TA they provided covered all or most of the categories listed, and they were unable to rank the categories most frequently offered, their responses were coded "all or most of above" categories.

The categories of T/TA offered most often by regional providers in FY 1974 and FY 1975 show a high degree of consistency. For both years, education T/TA was most frequently offered by most providers (FY 1974 - 52.8%; FY 1975 -50.7%). Second most frequently offered in FY 1974 was parent involvement T/TA (37.5%) and third, performance standards (36.1%). In FY 1975, handicapped T/TA was offered second most often (41.3%) and parent involvement was third (37.3%). Performance standards dropped to fourth (34.7%). The increased emphasis on handicapped T/TA in FY 1975 stems from the mandate Head Start was given to incorporate handicapped into their programs, and may also point out (1) that regional providers have increased skills in providing such T/TA, and (2) they are filling gaps in services needed to fulfill the mandate.

The national and regional providers manifested a high degree of congruency in categories of T/TA most frequently offered. Education was always mentioned by the majority of respondents in both groups, while performance standards, parent involvement, and handicapped T/TA ranked either second or third among these providers.

Regional variations occurred on a number of these categories. Tables D18 and D19, following this page, have been constructed to show the "norm" for each category (in this instance, calculated by dividing the total number of regional providers who answered the question for each year, by the number mentioning each particular category) against which each region's providers responses are compared.

Table D18. Comparison of Each Region's Regional Providers Offering Categories of T/TA in Fiscal Years 1974

Categories of T/TA	Percent of Each Region's Providers Offering T/TA							Percent of All Providers Offering T/TA (n=72)
	II (n=4)	III (n=14)	IV (n=14)	V (n=7)	VI (n=14)	X (n=9)	XI (n=10)	
Education	75.0	50.0	21.4	14.3	92.9	55.6	60.0	49.4
Parent Involvement	75.0	50.0	21.4	71.4	28.6	11.1	40.0	35.1
Social Services	25.0	7.1	21.4	--	--	22.2	--	9.1
Health	--	--	14.3	--	14.3	11.1	20.0	9.1
Medical	--	--	--	--	--	--	--	--
Dental	--	--	--	--	7.1	--	--	1.3
Mental	--	7.1	--	--	--	--	--	--
Nutrition	--	--	7.1	--	14.3	11.1	10.0	6.5
Handicapped	50.0	42.9	42.9	28.6	42.9	--	10.0	29.9
Needs Assessment	--	21.4	7.1	42.9	28.6	--	10.0	15.6
Administration	--	7.1	28.6	71.4	28.6	33.3	30.0	26.0
Management Skills	--	14.3	21.4	28.6	14.3	22.2	20.0	16.9
Fiscal Management	--	14.3	--	--	--	11.1	10.0	6.5
Record-Keeping	--	--	--	--	--	--	--	1.3
Performance Standards	--	57.1	21.4	42.9	28.6	33.3	50.0	33.8
Career Development	--	7.1	--	--	--	--	--	2.6
All or most of above*	25.0	--	21.4	--	--	22.2	10.0	9.1
Other	--	7.1	--	--	--	--	--	1.3

* Because some provider respondents answered that the T/TA they provided covered all or most of the categories listed, and they were unable to rank the categories most frequently offered, their responses were coded "all or most of above" categories.

Table D19. Comparison of Each Regions' Regional Providers Offering Categories of T/TA in Fiscal Year 1975

Categories of T/TA	Percent of Each Region's Providers Offering T/TA							Percent of All Providers Offering T/TA (n=72)
	II (n=4)	III (n=14)	IV (n=14)	V (n=7)	VI (n=14)	X (n=9)	XI (n=10)	
Education	75.0	38.5	27.8	12.5	92.9	62.5	60.0	49.4
Parent Involvement	75.0	61.5	27.8	50.0	35.7	--	30.0	36.4
Social Services	--	7.7	5.6	--	--	--	10.0	3.9
Health	--	--	16.7	12.5	21.4	25.0	--	11.7
Medical	--	--	--	--	--	12.5	--	1.3
Dental	--	--	--	--	--	--	--	--
Mental	--	7.7	--	--	--	--	--	1.3
Nutrition	--	--	16.7	12.5	7.1	--	--	6.5
Handicapped	25.0	46.2	44.4	50.0	35.7	62.5	20.0	40.3
Needs Assessment	--	23.1	27.8	37.5	14.3	--	20.0	19.5
Administration	--	7.7	11.1	50.0	28.6	25.0	50.0	23.4
Management Skills	--	23.1	11.1	25.0	14.3	12.5	10.0	14.3
Fiscal Management	--	15.4	5.6	--	7.1	12.5	10.0	7.8
Record-Keeping	25	--	--	--	--	12.5	--	2.6
Performance Standards	25.0	46.2	33.3	50.0	28.6	--	50.0	33.8
Career Development	--	7.7	5.6	--	--	--	10.0	5.4
All or most of above*	25.0	--	16.7	--	--	12.5	--	6.5
Other	--	--	11.1	--	7.1	--	10.0	5.2

* Because some provider-respondents answered that the T/TA they provided covered all or most of the categories listed, and they were unable to rank the categories most frequently offered, their responses were coded "all or most of above" categories.

These tables show the following regional variations:

- Region II providers were much higher than the "norm" for education and parent involvement for both years. These areas seem to be the primary focus of T/TA activity among this sample. The various health categories of T/TA were not offered in either year, and handicapped, which was higher than the "norm" for FY 1974, was lower in FY 1975. No needs assessment and virtually no administrative types of T/TA were offered either year.
- Region III providers generally were higher than the "norm" for most categories of T/TA. Parent involvement was much higher than the "norm" for both years; handicapped, which was higher in FY 1974, was closer to the "norm" in FY 1975, not because their providers' activities had changed appreciably, but because other regions offered this type T/TA more frequently. Performance standards T/TA, higher than the "norm" both years, declined somewhat in FY 1975. Education T/TA, which was lower than the "norm" in FY 1974, increased in FY 1975 which brought it to the "norm." Administration T/TA was much lower than the "norm" for both years. (Note: The number of providers used as a base in these two years changed in FY 1975. We interviewed 14 providers in all; for FY 1975 one provider indicated answering this question was "Not Applicable.")
- Region IV providers were below the "norm" both years in education and parent involvement, although in this latter category T/TA increased somewhat in FY 1975. Social services T/TA, much higher than the "norm" in FY 1974, declined noticably in FY 1975. Administrative types of T/TA, higher than the "norm" in FY 1974, were offered less in FY 1975, bringing them below the "norm." In FY 1975 more emphasis was placed on nutrition, needs assessment, and performance standards T/TA. (Note: The number of providers interviewed in this region was 18. For FY 1974, four providers indicated

that it was "Not Applicable" for them to answer this question. Therefore, the base number used in those tables is lower for FY 1974.)

- Region V providers were much lower than the "norm" on education T/TA, but much higher generally on parent involvement, needs assessment, administration, management skills, and performance standards T/TA in both years. Their emphasis on needs assessment and managerial functions may reflect the preparation efforts. The regional office feels necessary to more effectively and efficiently handle the move to direct-fund all local programs. (Note: One provider answered "Not Applicable" for FY 1974; therefore, the base number used for that year is seven, instead of the eight used for FY 1975.)
- Region VI providers were remarkably higher than the "norm" in offering education T/TA. For most other categories they were at or near the "norm." There was an increase in health T/TA offered in FY 1975 compared to FY 1974, but handicapped and needs assessment T/TA declined in FY 1975.
- Region X providers evidence a rather mixed pattern. Education T/TA was "higher" than the "norm" in FY 1975. In parent involvement, their T/TA for both years has been virtually nil. In FY 1974 social services T/TA was higher than the "norm," but dropped to no T/TA in FY 1975; this phenomenon was common for several regions' providers. Health and handicapped T/TA were both higher than the "norm" in FY 1975, and represent an increase over FY 1974 T/TA, particularly for handicapped which was not mentioned at all. Performance standards T/TA dropped to zero in FY 1975, although it can be assumed to have been incorporated by the 11.1% of providers who offered "all or most of the above." (Note: One provider in FY 1975 said it was "Not Applicable" to answer this section. Therefore, the number upon which the percentages are based is lower than for FY 1974.)

- Region XI providers were generally above the "norm" (especially for education and performance standards) in most categories of T/TA offered in FY 1974 except handicapped, which was lower. In FY 1975, their T/TA in most categories was at or near the "norm." The exceptions were: administration T/TA, in which they increased activity considerably, thus making it much higher than the "norm"; performance standards, which was at the same level as last year but still higher than the "norm"; and handicapped, which was lower than the "norm" (even though they slightly increased such T/TA) because of the other regions' increased activity.

Regional providers were next asked, "Do you participate at least once a year in any of the following activities to increase your skill and expertise?" The list in Table D20 shows the possible responses to this question on skill development activities, with the percent responding "Yes" to each item in the list.

Table D20. Participation in Skill Development Activities: Regional Providers (n=77)

Skill Development Activities	Percent of Regional Providers Participating
Attend refresher courses/ seminars/conferences	94.8
Read current literature in particular field	98.7
Collect new audio-visual materials	87.0
Collect new kits/packets	85.7
Subject self to evaluation from trainees	87.0
Other	11.7

NOTE: Compare this Table with Table D9 on National Providers and Table 13 on the RTO/STO Network.

(Note: There was another item in this listing which supposed to read "Subject self to evaluation from other trainers." Unfortunately, a typographical error which made "trainers" appear as "trainees" was not caught in the proofing process, and we have omitted this item from analytical consideration.)

The variation in responses is very narrow. Nearly all providers read current literature in their particular field of expertise and attended refresher courses or seminars. The category "other" included such responses as regular college or graduate level courses, professional associations, and advisory committees. On all items, the percentages of regional providers participating in these skill development activities were slightly higher than those of national providers.

No notable regional variations appeared on these items. However, some variations do occur when looking at each region's responses to "subject self to evaluation from trainees" and an earlier question asking if providers evaluated the T/TA they provided via "written reports from trainees." When the percentage for each region was higher on "subject self to evaluation from trainees" than on evaluate T/TA via "written reports from trainees", the differential may be attributed to verbal evaluation. But when the percent on the former item is lower than on the latter, it reveals an inflated response to the latter item, written evaluation. Two regions manifest this occurrence. One is Region VI, with 71.4% of the providers saying they subjected self to evaluation from trainees, but 85.7% saying they evaluated their T/TA with written reports from trainees. The other is Region X, with 77.8% subjecting self to evaluation from trainees and 100.0% evaluating T/TA with written trainee reports. We have recognized that, with all categories of respondents in this entire sample, there exists the probability that respondents will present themselves or their program in the most positive light, so that for a number of questions asked in the instruments, the response percentages are probably somewhat inflated compared to what is actually happening or felt. Here we have an indication of this assumption and, in fairness to Regions VI and X providers, it should be said that they are probably not unique.

c. Local Level Responses

Local level responses on this topic of T/TA resources utilized, and all other topics in this chapter on findings, are discussed first from the viewpoint of Directors, staff, and parents associated with the 30 Head Start programs sampled and then from that of local level T/TA providers.

1. Local Program Responses

Project staff interviewed a total of 428 directors, staff, and parents. (See Chapter II for an explanation of the selection process utilized.)

These respondents were first asked to specify the national providers from whom they received services during the past year. Their responses are presented in Table D21, following this page.

Among those surveyed, the most frequently used providers funded by OCD Headquarters were:

U.S. Public Health Service	32.0%
CDA Consortium	24.3%
American Academy Pediatrics	19.9%
Modern Talking Pictures	19.4%
ERIC	19.2%
Council Exceptional Children	18.9%

Regarding notable variations in these responses on a region-by-region basis, the following comments can be made:

- U.S. Public Health Service was most frequently mentioned by respondents in Region XI IMPD (45.9% vs. the "norm" of 32%) followed by Region X Seattle (41.8%) and Region VI Dallas (40.4%). USPHS was mentioned least often by interviewees in Region V Chicago (14.3%)

Table D21. National Providers Utilized by Local Programs (n=428)

Providers	Number / Percent Yes
Health	
American Academy of Pediatrics	85 / 19.9
U.S. Public Health Service	137 / 32.0
American Psychological Association	46 / 10.7
American Dietetic Association	34 / 7.9
Handicapped	
Council for Exceptional Children	81 / 18.9
Technical Assistance Development System	34 / 7.9
Communications Research Lab	13 / 3.0
Materials	
Modern Talking Pictures	83 / 19.4
Educational Resources Information Center (ERIC)	82 / 19.2
Inter-American Research Association	6 / 1.4
HSST/CDA	
High Scope Foundation	27 / 6.3
CDA Consortium	104 / 24.3
UNIDOS Management Association	6 / 1.4
Specific Grantee (IMPD, PCC, CFRP)	
Social Dynamics	28 / 6.5
Trancendental Corporation	14 / 3.3

- CDA Consortium was mentioned more often than the "norm" of 24.3% by respondents in Regions XI IMPD (39.3%) and X Seattle (34.5%).
- American Academy of Pediatrics was given as an answer 31.3% of the time by Region II New York respondents, more often than any other region or the "norm" of 19.9% when all seven case study regions are aggregated.
- Modern Talking Pictures, according to this group of respondents, was less used in Region X Seattle and Region XI IMPD than in the other five regions sampled. Since the frequency of response in those two regions was 12.7% and 13.1% respectively, vs. the "norm" of 19.4% reached by compiling the responses of all 428 interviewees across the seven case studies.
- Council for Exceptional Children was reported by 31% of the Region IV Atlanta respondents as being used a considerably higher frequency of response than in any other region or than the "norm" of 18.9% across the seven regions.

Then all respondents in this category were asked what percent of all the T/TA they received in the past year came from national providers. Aggregating answers across the seven regions resulted in the distribution by decile shown here in Table D22, following this page.

Table D22. Percentage of T/TA From National Providers: Local Programs (n=428)

Decile	Number	Percent Yes
None	71	16.6
1 - 10%	111	25.9
11 - 20%	27	6.3
21 - 30%	25	5.8
31 - 40%	11	2.6
41 - 50%	18	4.2
51 - 60%	1	0.2
61 - 70%	0	0.0
71 - 80%	4	0.9
81 - 90%	1	0.2
91 - 100%	1	0.2
Don't Know	73	17.1
No Response	85	19.9

The largest concentration of responses falls within the first decile, 1 - 10%, since 111 answers or roughly one-quarter of all responses (25.9%) cluster there. In fact, the total number of answers distributed among the other nine deciles does not equal the number in the first decile. The other significant finding here is the large number of interviewees (71 of 16.6% of the total) who reported no reception of T/TA from a national provider. This however again may be explained by the fact that parents' answers have been equally considered here with those of directors and staff, even though they might not be as keenly aware of the exact source of T/TA received.

A cross tabulation was made of this data on percentage of T/TA from national providers with level of satisfaction with T/TA received. No significant bivariate relationship could be shown. The same thing happened when this data was crossed with the level of impact T/TA had.

Next these respondents were asked to specify the regional providers whom they received services during the last year. Their responses are presented here in Table D23.

Table D23. Regional Providers Utilized by Local Programs (n=428)

Type of Regional Provider	Number	Percent Yes
Head Start Supplementary Training	166	38.8
Child Development Associate Program	146	34.1
State (Regional)Training Office	234	54.7
Other	48	11.2

Those who were interviewed responded most frequently that they received regional-level T/TA from the State or Regional Training Office (54.7%), then from HSST (38.8%) and the CDA Program (34.1%).

Regarding noteworthy differences in these responses from one region to another, these observations can be made:

- State (Regional) Training Offices were mentioned as a source of regional-level T/TA more often than the "norm" of 54.7% by:
  - -- Region X Seattle 67.3%
  - -- Region II New York 66.7%
  - -- Region III Philadelphia 64.1%
  - -- Region VI Dallas 63.5%
- HSST or Head Start Supplementary Training was given as a response more frequently in Region III Philadelphia, 52.6%, than in any other region by far, and more than the "norm" of 38.8%; conversely only 18.3% of Region IV Atlanta interviewees gave this answer.

- Child Development Associate (CDA) Program was listed more frequently by Region XI IMPD respondents (52.5% of the time) than any other region and than the "normal" frequency of response of 34.1%; Region X Seattle (47.3%) and Region VI Dallas (44.2%) were the other two whose respondents gave the CDA answer at a more frequent rate than the "norm." By comparison, Region IV Atlanta respondents mentioned CDA as a source only 16.9% of the time, which is the smallest percentage of any of the seven case studies.

Then all respondents in this category were asked what percent of all the T/TA they received in the past year came from regional providers. Aggregating answers across the seven case studies results in the distribution by decile shown here in Table D24.

Table D24. Percentage of T/TA From Regional Providers: Local Programs (n=428)

Decile	Number	Percent Yes
None	20	4.7
1 - 10%	44	10.3
11 - 20%	26	6.1
21 - 30%	41	9.6
31 - 40%	29	6.8
41 - 50%	44	10.3
51 - 60%	9	2.1
61 - 70%	11	2.6
71 - 80%	25	5.8
81 - 90%	13	3.0
91 - 100%	18	4.2
Don't Know	66	15.4
No Response	82	19.2

Two deciles contain the largest concentration of answers to this question: the first (1 - 10%) and the fifth (41 - 50%), each of which

had 10.3% of the total responses. The third decile (21 - 30%) received 9.6% of all the responses. The number of interviewees who answered "None" to this question (20 all told, equalling 4.7% of the total) dropped sharply from the 71 or 16.6% of the same group who said "None" when asked how much national provider T/TA they received.

A cross tabulation was made of this data on percentage of T/TA from regional providers with level of satisfaction and also with amount of impact caused by T/TA received. In both cases, no statistically significant result was achieved.

Next these directors, staff, and parents were requested to specify the local providers from whom they received services during the past year. It developed that some local programs who are direct-funded buy needed T/TA with PA 20 (Program Account 20, for T/TA) funds while others who are not direct-funded (and therefore have no PA 20 monies available) purchase T/TA from local providers out of their normal operating program funds.

The answers about local providers utilized as a source of T/TA are presented here in Table D25. The responses of those who have PA 20 monies have been separated from those who do not.

Table D25. Local Providers Utilized by Local Programs (n=428)

Type of Providers	Number / Percent Yes (PA 20)*		Number / Percent Yes (Program Dollars)	
Public Schools	20	4.7	4	0.9
Universities/Colleges	47	11.0	17	4.0
Community Agency (Public)	39	9.1	12	2.8
Community Agency (Private)	9	2.1	5	1.2
Private Firms	5	1.2	2	0.5
Churches	2	0.5	0	0.0
Private Consultants	39	9.1	17	4.0
Other	9	2.1	7	1.6

* No direct-funded programs were sampled in Regions II, VI, X; so therefore, this data does not pertain to those regions.

Those surveyed most frequently reported overall receiving locally purchased T/TA from:

-- Universities/colleges 15.0% frequency
-- Private consultants 13.1% frequency
-- Public community agency 11.9% frequency

Even if the responses of those interviewed in programs with available PA 20 funds are considered alone, the same three types of local providers end up being most frequently mentioned:

-- Universities/colleges 11.0% frequency
-- Private consultants 9.1% frequency
-- Public community agency 9.1% frequency

Also if these responses alone are considered, several noteworthy regional variations can be observed:

- Universities or colleges as a source of local level T/TA was mentioned most frequently far and away by the 63 respondents in Region V Chicago--25.4% or one-fourth of them cited this source as opposed to the "normal" frequency across all seven case studies of 11%. However, this sort of a comparison against the "norm" is specious since three of the seven regions (II New York, VI Dallas, and X Seattle) all had zero responses for universities/colleges as a source of local T/TA. Nonetheless, among the four regions who reported some T/TA from this source, V Chicago was easily the leader. Since Region V is committed to providing all programs with some PA 20 monies, this result is not surprising.
- Private consultants also were mentioned as a source more frequently by Region V Chicago respondents than any others, 27% or 17 of the 63 persons interviewed there gave this as a T/TA local source. The "norm" of 9.1% frequency of response again is suspect because two regions, II New York and X Seattle, had no respondents listing universities/colleges as a source of local T/TA.

- Public community agencies were mentioned consistently by about one-sixth of the respondents in Regions IV Atlanta (16.9%), V Chicago (15.9%), and XI IMPD (16.4%) as a source for local T/TA.

Then all respondents in this category were asked what percent of all the T/TA they received in the past year came from local providers. Aggregating answers across the seven case study regions results in the distribution by decile shown here in Table D26. The responses of those whose programs have PA 20 monies available for T/TA purchasing have been separated from those who do not.

Table D26. Percentage of T/TA From Local Providers: Local Programs

Decile	Number / Percent Yes (PA 20)*		Number / Percent Yes (Program Dollars)	
None	13	3.0	0	0.0
1 - 10%	12	2.8	11	2.6
11 - 20%	12	2.8	4	0.9
21 - 30%	10	2.3	5	1.2
31 - 40%	6	1.4	8	1.8
41 - 50%	16	3.7	3	0.6
51 - 60%	1	0.2	4	0.9
61 - 70%	0	0.0	1	0.2
71 - 80%	5	1.2	1	0.2
81 - 90%	4	0.9	4	0.9
91 - 100%	1	0.2	1	0.2

(Total responses reflected in this table is 122, leaving 306 "Don't Knows" o "No Responses." This happened because of confusion in the questionaire regarding who was to be asked this question.)

* No direct-funded programs were sampled in Regions II, VI, X; so therefore, this data does not pertain to those regions.

The most startling finding here is the extremely large numbers of No Responses or Don't Knows. This apparently is explained in large part because (a) only nine of the 30 programs sampled are direct-funded (i.e., have any PA 20 funds with which to purchase T/TA) or (b) few respondents were aware of how their local program actually obtained directly purchased T/TA. This is another instance of where being able to separate out the responses of the directors from those of the staff and parents would probably be very enlightening. It would also be helpful, no doubt, to isolate the answers of only the direct-funded program respondents from the others.

A cross tabulation was made of this data on percentage of T/TA from local providers with level of satisfaction and also with amount of effect or impact caused by T/TA received. In both instances, no statistically significant result was achieved.

Next, this same group of 428 respondents were asked to specify the non-Head Start sources (free) from whom they received services during the last year. Their responses were presented here in Table D27.

Table D27. Non-Head Start Sources Utilized by Local Programs (n=428)

Non-Head Start Sources (Free)	Number / Percent Yes		Number / Percent No	
Public Schools	129	30.1	299	69.9
Universities/Colleges	162	37.9	266	62.1
Community Agency (Public)	195	45.6	233	54.4
Community Agency (Private)	75	17.5	353	82.5
Private Firms	45	10.5	383	89.5
Churches	50	11.7	378	88.3
Private Consultants	115	26.9	313	73.1
Other	34	7.9	394	92.1

This group of respondents mentioned most frequently for four free sources of T/TA services:

Public Community Agencies	45.6% frequency of response
Universities/colleges	37.9% frequency of response
Public schools	30.1% frequency of response
Private consultants	26.9% frequency of response

This data seems to support two conclusions: (1) Head Start programs seem to be having remarkable success in getting grafis help from local sources and (2) private consultants, in spite of their proprietary classification, seem to be making substantial contributions to local programs. The same should be said, of course, for those colleges and universities referred to by the respondents which are not publicly-supported.

Regarding notable differences among the seven regions sampled, several items can be singled out:

- Public community agencies were mentioned most frequently as a free source of T/TA by Region X Seattle respondents (60.0%), more often than any other region, or the "norm" of 45.6% representing the frequency of response when all 428 answers across the seven regions are aggregated.
- Universities or colleges were listed as a free source by well over half the respondents (57.7%) in Region VI Dallas, which figure is considerably above the "norm" of 37.9% as well as any individual case study; conversely Region IV Atlanta interviewees mentioned this source only 16.9% of the time.
- Public schools were reported as a free source by about half the Region V Chicago respondents (49.2%), again well above the figure for any of the other six regions and the "norm" of 30.1% as well; Region XI IMPD mentioned this source only 8.2% of the time--and Region IV's Atlanta rate of response to this item was not much greater--12.7%.

Private consultants received significantly more mentions as a free T/TA source in Region X Seattle (58.2%) than in any other region; the "norm" across all seven case studies was 26.9% frequency of response; Region IV Atlanta respondents gave this answer only 8.5% of the time--the lowest frequency of any region sampled.

Then all respondents in this category were asked what percent of all the T/TA they received in the past year came from local providers. Aggregating answers across the seven case study regions results in the distribution by decile shown here in Table D28.

Table D28. Percentage of T/TA From Non-Head Start Sources: Local Programs (n=428)

Decile	Number	Percent
None	35	8.2
1 - 10%	51	11.9
11 - 20%	39	9.4
21 - 30%	36	8.4
31 - 40%	18	4.2
41 - 50%	29	6.8
51 - 60%	14	3.3
61 - 70%	9	2.1
71 - 80%	14	3.3
81 - 90%	4	0.9
91 - 100%	13	3.0
Don't Know	64	15.0
No Response	102	23.8

Clearly the first three deciles, 1 - 10%, 11 - 20%, and 21 - 30% have the largest clusters of responses for the percentage of T/TA obtained from free sources. Taken together, they contain 29.4% of the responses made to this question. In other words, nearly one-third of

the interviewees have reported that services comprising up to 30% of their total T/TA program are gotten free from various non-Head Start sources. What's more, 29 other respondents, representing 6.8% of this category of directors, staff, and parents, reported that free T/TA constitutes 41% to 50% of their total available T/TA. These findings are compatible with earlier ones in this section which strongly support the conclusion that Head Start programs seem to be having remarkable success in getting gratis help from local sources.

A cross tabulation was made of this data on percentage of T/TA from non-Head Start sources with level of satisfaction and also with amount of effect caused by T/TA received. In both cases, no significant results were achieved.

At this point, it seems appropriate to display comparatively the findings uncovered from the data concerning percent of T/TA received by this category of respondent from national, regional, local, and non-Head Start sources. This data is presented accordingly in Table D29.

Table D29. Comparison by Percent of T/TA Sources Utilized

Decile	National	Regional	Local	Non-Head Start
None	16.6%	4.7%	3.0%	8.2%
1 - 10%	25.9%	10.3%	5.4%	11.9%
11 - 20%	6.3%	6.1%	3.7%	9.1%
21 - 30%	5.8%	9.6%	3.5%	8.4%
31 - 40%	2.6%	6.8%	3.2%	4.2%
41 - 50%	4.2%	10.3%	4.3%	6.8%
51 - 60%	0.2%	2.1%	1.1%	3.3%
61 - 70%	0.0%	2.6%	0.2%	2.1%
71 - 80%	0.9%	5.8%	1.4%	3.3%
81 - 90%	0.2%	3.0%	1.8%	0.9%
91 - 100%	0.2%	4.2%	0.4%	3.0%
Don't Know	17.1%	15.4%	72.0%	15.0%
No Response	19.9%	19.2%		12.8%

Includes local T/TA both from PA 20 and program monies.

NOTE: This Table incorporates data previously displayed in Tables D22, D24, D26 and D28.

The same comments made earlier when discussing each source obviously still apply. This table, however, provides an overview of the distribution of responses regarding all four T/TA sources. In reading this table, remember that the first column represents the deciles, and the other four columns report the percentage of directors, staff, and parents who said they received "x"% T/TA from a given source. For example, 25.9% of all 428 respondents in this category said they get anywhere from 1% to 10% of their total T/TA from national providers; by comparison, only 10.3% of the interviewees said they received a comparable amount from regional providers, etc.

One interesting perspective on these findings can be had by asking how large a percent of respondents reported receiving anywhere from 1% to 50% of all their available T/TA from any one of the four sources. The facts are:

44.8% of the 428 interviewees reported receiving from 1% to 50% of all their T/TA from national providers

43.1% of the 428 interviewees reported receiving from 1% to 50% of all their T/TA from regional providers

20.1% of the 428 interviewees reported receiving from 1% to 50% of all their T/TA from local providers

40.4% of the 428 interviewees reported receiving from 1% to 50% of all their T/TA from non-Head Start sources

It could be concluded from this, apparently, that there is a fairly even balance among national, regional, and non-Head Start sources as far as supplying the 30 local programs with T/TA is concerned. Again, it seems remarkable that these local programs are getting as much free T/TA from non-Head Start resources as they are from either national or regional providers.

These findings suggest another possible conclusion, namely that, even though nine of the 30 local programs studied are direct-funded, i.e., can purchase their own T/TA, only 20.0% of the respondents reported

receiving up to 50% of all their T/TA from local resources. It seems that since nine of 30 programs (roughly 30%) of the programs are direct-funded that approximately 9/30ths (roughly 30%) of the respondents would be from these programs and that they, theoretically, should be, in greater numbers than they did, reporting reception of up to one-half their total available T/TA from direct purchase.

2. Local Provider Responses

Local providers, like the other providers, were queried about the time available to them to arrange for and/or provide services, because this aspect bears on the issue of T/TA delivery. In an effort to develop an indication of how providers utilize their time, the question was asked, "do you attempt to distribute your time according to any set formula, e.g., 30% to coordinating T/TA activities, 30% to providing consulting help directly to the locals, 20% providing training to Head Start Grantees and 20% to administrative tasks?" Local providers responded:

Table D30. Distribution of Time to a Set Formula: Local Providers (n=24)

Responses	Percent
Yes	16.7
No	62.5
Don't Know	4.2
Not Applicable	16.7

NOTE: Compare this Table with Table D5 on National Providers and Table D14 on Regional Providers.

Very few local providers did try to use a formula for distributing their time. The number is much smaller than for either regional (53.2%) and national (38.2%).

When the four who said "Yes" were asked to explain their formula, only three answered. Their responses were that one spent 100% of his time on T/TA; another 70% T/TA and 30% administration, and the third 50% T/TA, 50% administration. The numbers involved are low, and it should be remembered that other local providers who did not have a formula may have spent considerable time in the field delivering T/TA also.

Then another set of factors affecting the delivery of T/TA was probed with local providers by asking them the basis used to determine when and how often to visit the local grantee. Table D31 arrays the responses.

Table D31. Basis for Local Providers' Visits to Regional Office and/or Local Grantee (n=24)

Basis for Visiting Local Grantees	Percent
At their request	70.8
Routinely (based on T/TA plan)	41.7
National Office recommendation	--
Regional Office recommendation	16.7
Crisis intervention	33.3
Other	12.5

NOTE: Compare this Table with Table D7 on National Providers and Table D16 on Regional Providers.

Most respondents (70.8%) said their visits were based on the request of the local grantee. This figure is lower than for regional providers (92.2%) and higher than national providers (61.8%). Over 40% indicated visiting routinely, on the basis of the T/TA plan, compared to 68.8% of regional providers, and 38.2% of national providers. Visiting for crisis intervention were 33.3% of local providers, a lower proportion than that for regional (64.9%) and national (38.2%) providers. This last information suggests that programs served locally may be able to head off problems before they get acute and require crisis

intervention, although without a split of the data according to direct-funded and non-direct-funded programs such a suggestion is tentative. The category "other" referred to self-initiated visits.

A comparison of local providers' responses about visiting programs based on the T/TA plan (41.7%) with the number who write T/TA plans (87.5%) (see Table M62) reveals that, like the other providers, there was a lack of specificity about visitation requirements in the plan. In fact, the differential between these two figures was greatest for local providers. It would appear that, while most local providers manifested a high level of flexibility in visiting upon request (70.8%), the majority did not incorporate into their plans a preconceived and continuous level of T/TA with follow-up. Now, in actuality, this kind of T/TA may have occurred, and the presumed close relationship between a local program and providers it hires may lessen the need for written procedures of this nature. But in terms of accountability, this situation raises doubts.

Some regional variations occurred among these bases used to determine visits:

- The "norm" for visiting at the request of local grantees was 70.8%; Region III (Philadelphia) providers were much lower than this (33.3%), while Region XI (IMPD) providers were much higher (100.0%);
- The "norm" for visiting because of regional office recommendation was 16.7%; Region III (Philadelphia) and Region XI (IMPD) providers indicated this basis to a higher degree (33.3% each), while Region V (Chicago) providers unanimously said it never happened (0.0%);
- The "norm" for visiting based on crisis intervention was 33.3%; Region V (Chicago) providers were lower (22.2%), and Region XI (IMPD) providers much higher (66.7%).

As regards this last item, in Region XI, a greater number of providers indicated visiting for crisis intervention purposes than did both types of providers in other regions. Given the unique conditions and needs of IMPD grantees, this finding is not surprising.

Continuing questions on the topic of resources utilized in T/TA delivery, we asked local providers to specify the three categories of T/TA the most frequently offered in Fiscal Years 1974 and 1975. As with national and regional providers, a few local providers answered "Not Applicable" to this question. The reason for this response was that the contract was for only one year. Thus, for Fiscal Year 1974, five local providers sampled were in this category, and for Fiscal Year 1975, two local providers. We have followed the same procedure for these providers as with the others, in that the percentages which appear in the following table are based on the total number who named categories each year, excluding not applicable responses.

Table D32 presents the data. A majority of local providers gave education T/TA most frequently in both fiscal years. Second most frequently offered both years was handicapped T/TA. And parent involvement was third, although in FY 1974 social services and health T/TA were offered as frequently as parent involvement. Table D32 follows this page.

Some regional variations surface, and Tables D33 and D34 have been constructed to show the percent of each region's local providers who offered each category of T/TA in FY 1974 and FY 1975. For these providers also, the "Not Applicable" responses were excluded, so the number of local providers in each region upon which the percentages are based varies from year to year. Tables D33 and D34 follow Table D32.

Several key findings emerge from these two previous Tables, D33 and D34:

- Region III (Philadelphia) local providers sampled offered T/TA only in a few categories: education, mental health, nutrition, and handicapped. In every instance their percents were higher than the "norm." It should be remembered, however, that the number sampled is very small.

Table D32. Categories and Rank Order of T/TA Most Frequently Offered by Local Providers in Fiscal Years 1974 and 1975

Categories of T/TA	Fiscal Year 1974		Fiscal Year 1975	
	Percent (n=19)	Rank Order	Percent (n=22)	Rank Order
Education	57.9	1	63.6	1
Parent Involvement	21.1	3	22.7	3
Social Services	21.1	3	18.2	4
Health	21.1	3	18.2	4
Medical	15.8	4	13.6	5
Dental	10.5	5	9.1	6
Mental	5.3	6	9.1	6
Nutrition	15.8	4	9.1	6
Handicapped	42.1	2	36.4	2
Needs Assessment	15.8	4	13.6	5
Administration	10.5	5	4.5	7
Management Skills	--	-	--	-
Fiscal Management	--	-	--	-
Record-Keeping	--	-	4.5	7
Performance Standards	5.3	6	9.1	6
All of most of above	5.3	6	4.5	7
Other	10.5	5	9.1	6

NOTE: Compare this Table with Table D8 on National Providers and Table D17 on Regional Providers.

Table D33. Comparison of Each Region's Local Providers Offering Categories of T/TA in Fiscal Year 1974

Categories of T/TA.	III (n=3)	IV (n=2)	V (n=6)	XI (n=2)	Percent of All Providers Offering T/TA (n=19)
Ecuation	100.0	50.0	50.0	50.0	57.9
Parent Involvement	--	--	66.7	--	21.1
Social Services	--	12.5	50.0	--	21.1
Health	--	37.5	16.7	--	21.1
Medical	--	12.5	16.7	50.0	15.8
Dental	--	12.5	16.7	--	10.5
Mental	33.3	--	--	--	5.3
Nutrition	33.3	--	33.3	--	15.8
Handicapped	100.0	37.5	33.3	--	42.1
Needs Assessment	--	25.0	--	50.0	15.8
Administration	--	12.5	16.7	--	10.5
Management Skills	--	--	--	--	--
Fiscal Management	--	--	--	--	--
Record-Keeping	--	--	--	--	--
All or most of the above	--	12.5	--	--	5.3
Other	--	11.5	--	50.0	10.5

NOTE: No direct-funded programs were sampled in Regions II, VI, or X; hence those regions are not included in this tabular presentation.

Table D34. Comparison of Each Region's Local Providers Offering Categories of T/TA in Fiscal Year 1975

Categories of T/TA	III (n=2)	IV (n=8)	V (n=9)	XI (n=3)	Percent of All Providers Offering T/TA (n=22)
Education	100.0	37.5	77.8	66.7	63.6
Parent Involvement	--	--	55.6	--	22.7
Social Services	--	--	44.4	--	18.2
Health	--	37.5	11.1	--	18.2
Medical	--	12.5	11.1	33.3	13.6
Dental	--	25.0	--	--	9.1
Mental	50.0	--	11.1	--	9.1
Nutrition	--	--	22.2	--	9.1
Handicapped	50.0	37.5	33.3	33.3	36.7
Needs Assessment	--	25.0	--	33.3	13.6
Administration	--	12.5	--	--	4.5
Management Skills	--	--	--	--	--
Fiscal Management	--	--	--	--	--
Record-Keeping	--	12.5	--	--	4.5
Performance Standards	--	--	11.1	33.3	9.1
All or most of above	--	12.5	--	--	4.5
Other	--	12.5	--	33.3	9.1

NOTE: No direct-funded programs were sampled in Regions II, VI, or X; hence those regions are not included in this tabular presentation.

- Region IV (Atlanta) providers were lower than the "norm" for education in both years. These providers' activities focus primarily on health, handicapped, needs assessment, and administration T/TA and, for the most part, the percent of local providers involved in each category is just at or above the "norm."
- Region V (Chicago) providers show a much higher than average percent T/TA in parent involvement and social services for both years. Education T/TA was increased in FY 1975 and was above the "norm." Nutrition T/TA was higher than the "norm" for both years. Other categories of T/TA offered were near the "norm."
- Region XI (IMPD) local providers offered T/TA in only a few categories. They were above the "norm" for medical and needs assessment T/TA in both years. In FY 1975, performance standards T/TA was given in contrast to FY 1974. It should be remembered that, as with Region III, the number of local providers sampled is very small.

A comparison of these findings with that of other providers has been made in Table 035. There is certainly complete unaminity of all providers regarding education T/TA being most frequently offered in both fiscal years. Local providers, unlike the other two groups, did not offer performance standards T/TA often enough for it to rank among

the three most frequently mentioned. Table D35 is presented below:

Table D35. Rank Order of Three Most Frequently Offered Categories of T/TA in Fiscal Years 1974 and 1975 by National, Regional, and Local Providers

Categories of T/TA	National Providers		Regional Providers		Local Providers	
	FY 74	FY 75	FY 74	FY 75	FY 74	FY 75
Education	1	1	1	1	1	1
Performance Standards	2	-	3	-	-	-
Parent Involvement	-	2	2	3	3	3
Handicapped	3	-	-	2	2	2
Health	-	2	-	-	3	-
Administration	-	3	-	-	-	-
Needs Assessment	3	-	-	-	-	-
Social Services	-	-	-	-	3	-

NOTE: This Table incorporates data previously displayed in Tables D8, D17, and D32.

Handicapped T/TA has been a focus for local providers in both years, in contrast to the other providers. Parent involvement emerges as a component in which T/TA has been consistently offered across all categories of providers.

As with the other providers, local providers were also asked "Do you participate at least once a year in any of the following activities to increase your skill and expertise?" The list of skill development activities and their responses appear below in Table D36.

Table D36. Participation in Skill Development Activities: Local Providers (n=24)

Skill Development Activities	Percent of Local Providers Participating
Attend refresher courses/seminars/ conferences	91.7
Read current literature in particular field	95.8
Collect new audio-visual materials	83.3
Collect new kits/packets	70.8
Subject self to evaluation from trainees	66.7
Other	4.2

(NOTE: There was another item in this listing which was supposed to read "Subject self to evaluation from other trainers." Unfortunately, a typographical error which made "trainers" appear as "trainees" was not caught in the proofing process, and we have omitted this item from analytical consideration.)

NOTE: Compare this Table with Table D9 on National Providers and Table D13 and Table D20 on Regional Providers.

More variations are found among local providers than the other providers. While the first three items from the list are activities with high percentage participation, the figures drop for collecting new kits and packets and for subjecting self to evaluation from trainees. On this latter, item, the percent for local providers is about 20% lower than for national (82.4%) and regional (87.0%) providers.

Also on this item appears the only significant regional variation among local providers. Virtually all the local providers who did not subject themselves to evaluation from trainees were from Region IV, and this

group of Region IV providers constituted 77.8% of all the local providers in that region. Interestingly enough, the remaining percent who did subject themselves to evaluation from trainees (22.2%) is much lower than the percent from Region IV who answered on an earlier question that they evaluated their T/TA via written reports by trainees (44.4%). As was discussed in the section treating the same questions from regional providers, (see Tables D13 and D20), we had expected inflated positive responses to several question in the instruments, and these findings reveal that very occurrence. The provision which should be mentioned, however, is that Region IV's providers are probably not alone. Our data simply does not reveal other regional discrepancies.

Summation of D2 Findings: T/TA Resources Utilized

The question addressed in this section was how does Head Start utilize its available T/TA resources.

The best data uncovered on this topic came from the local level respondents. Our sample of 428 respondents were each asked what percent of their total T/TA package came from national, regional, local providers or non-Head Start sources. Considering together all responses of up to 50% from any one source reveals these findings: (See Table D29)

44.8%	received 1-50% of all their T/TA from	national	sources
43.1%	"	regional	sources
20.1%	"	local	sources
40.4%	"	non-Head Start	sources

These data tend to indicate that the local level programs sampled are receiving T/TA from all 3 levels of Head Start (national, regional, and local) in a rather balanced pattern. The only source of T/TA among these three that seems underutilized according to our data is local providers. Approximately 30% of the local program people interviewed were supposedly affiliated with a directly-funded program, yet only 20.0% of the respondents reported receiving from 1 to 50% of their total T/TA from local providers. This seems to be a lower figure than would be expected and one that is difficult to explain.

Another surprise surfaced in these data, and that is that respondents at the local level said they get almost as much T/TA from non-Head Start (i.e. free) sources as from national providers or from regional providers. In other words, local programs sampled are utilizing "gratis" T/TA from non-Head Start sources just about as much as that made available to them via national or regional providers. This is one of our most significant findings, we believe, and can be viewed as a tribute to the local program people for soliciting outside help and to the donors of the help for providing it.

An interesting historical connection can be made in this regard by Kirschner Associates. In May of 1970 we concluded in our Final Report to

OCD on A National Survey of the Impacts of Head Start Centers on Community Institutions that educational and health institutions "have changed remarkably ...(and) have become concerned with the needs and the problems of the poor and of the minorities." Now, five years later, as Head Start enters its second decade of existence, KAI reports further and more extensive data showing that local institutions, e.g., health and education organizations, continue to get involved in helping the poor and minorities through Project Head Start.

All that has so far been said in this summation was gleaned from data obtained from program people. Information on this topic was also sought from providers; however the focus of the questioning with them was quite different. They were asked a number of questions about how they manage their own resources, e.g., their time, their arrangements for visiting their consumers, their opportunities for in-service training:

- regarding whether or not providers devise a formula for use of their time, the results were as follows: (See Tables D5, D14, D30)

National providers	32.2% yes
Regional "	53.2% yes
Local "	16.7% yes

- regarding the basis for arranging their visits to consumers, the providers sampled answered as follows: (See TAbles D7, D16, D31)

	National	Regional	Local
At request of grantee	61.8%	92.8%	70.8%
Routinely (based on T/TA plan)	38.2	68.8	41.7
Crisis intervention	38.2	64.9	33.3

- regarding whether or not providers participate in activities designed to increase their skills and expertise, the results on specific skill development activities were as follows: (See Tables D9, D20, D36)

	National	Regional	Local
Attend courses, etc.	88.2%	94.8%	91.7%
Read current lit.	94.1	98.7	95.8
Collect new A-V materials	79.4	87.0	83.3
Trainee evaluation	82.4	87.0	66.7

Each of these measures of the way providers manage resources available to them to facilitate their delivery of T/TA to Head Start tends to show that the regional providers sampled on the whole are more alert and aggressive in the way they do the preparatory work for providing T/TA to the consumers.

The providers were also asked what categories of T/TA they offered most frequently. As summarized in Table D35, the results were unanimous in favor of education as far and away the most frequently offered T/TA category by all 3 levels of providers (national, regional and local) in both FY 74 and FY 75. Parent involvement T/TA also rated highly across all 3 levels; the same is true for handicapped services T/TA. Performance standards T/TA was given high ratings by both national and regional providers. In general these results tend to indicate a close correlation between the content of T/TA offered by providers and the operative and current Head Start objectives, policy and guidance. Once again we have confirmation of a conclusion drawn in the Summation of Section M1, namely that Head Start "objectives which have the force of policy behind them receive the greatest attention and effort at implementation."

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION D3. How effectively are other supportive resources being utilized?

KAI believed that, just as it was important to investigate how well Head Start was utilizing resources that were subsidized out of its own funds, so too it was critical to look into how well other supportive non-Head Start subsidized resources were being used. This is the same distinction that was drawn in the previous Section, D2, when local Head Start T/TA sources were considered separately from non-Head Start T/TA sources (see Tables D27 and D28). Data has already been presented showing that the local programs sampled tended to get as much T/TA from non-Head Start or "supportive resources" as they did from either national or regional providers (see Table D29). This section, D3, will focus more closely on these supportive resources, in as much as this phenomenon seems to be such a significant one. Parents will also be considered, in the last part of this section, as a "supportive resource," in order to focus on their contributions to Head Start as well.

Supportive resources may be in the form of personnel, services, materials or equipment. Such supportive resources provide assistance or facilitate T/TA activities--but they do not constitute any essential part of the process, nor do such resources bear any primary responsibility for any part of the T/TA process.

In this section, the topic of supportive resources will be addressed at the local level only and from the viewpoint of directors, staff, parents, and community leaders.

c. Local Level (Program) Responses

In regard to services offered by their programs, the directors, staff, and parents were asked how supportive and cooperative they thought their local community leaders were (e.g., donating space, time, expertise, etc.) They were given a five point scale on which to answer: "a great deal, quite a bit, some, a little, none." Their answers are displayed here in Table D37.

Table D37. Support, Cooperation of Community Leaders (DSP n=428)

COMLDRSP	REGION							
	COUNT / ROW PCT / COL PCT / TOT PCT	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	TOTAL
20. A GREAT DEAL								
21. QUITE A BIT								
22. SOME								
23. A LITTLE								
24. NONE								
88. DON'T KNOW								
99. NOT APPL								
COLUMN TOTAL								

The findings uncovered by this data are essentially very favorable ratings by the directors, staff and parents regarding the support and cooperation they get from their local community leaders. Six out of ten respondents (61.2%) said the community leaders supported and cooperated with them at least "quite a bit"; 83.4% said they got, at a minimum, "some" support and cooperation. Only 8.9% said "a little" and a meager 2.1% report no support or cooperation.

The conclusion is that this finding tends to reinforce those in the previous section regarding non-Head Start sources, which inidcated large percentages of local level T/TA being received from free sources, such as those over which these community leaders presumably would have various degrees of control.

Regarding regional differences on perceptions by these respondents of the support and cooperation given by local community leaders, Region IV (Atlanta) and Region VI (Dallas) exceeded the "norm" of 61.2% for the frequency of "a great deal" and "quite a bit" responses. The former gave these answers 71.8% of the time, the latter 71.1%. Region X (Seattle) conversely, registered these two most favorable responses 52.8% of the time, the lowest frequency of any of the 7 regions and the frequency most below the "norm" of 61.2%, arrived at by aggregating all responses from the case studies.

This same question, i.e., with regard to the services offered by the local H.S. program, how supportive and cooperative are the community leaders, was also asked of the community leaders themselves. Their answers are presented here in Table D38.

Table D38. Support, Cooperation of Community Leaders (CL m-162)

SPTCPNCL	COUNT / ROW PCT / COL PCT / TOT PCT	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN
A GREAT DEAL	1.	8	10	12	10	10	4	
		13.1	16.4	19.7	16.4	16.4	6.6	11.
		53.3	38.5	44.4	37.0	52.6	20.0	41.
		5.3	6.6	7.9	6.6	6.6	2.6	6.
QUITE A BIT	2.	4	6	8	9	3	9	
		9.3	14.6	18.7	18.9	6.3	18.8	18.
		26.7	23.1	29.6	33.3	15.8	45.0	52.
		2.6	4.0	5.3	6.3	2.0	6.0	6.
SOME	3.	3	7	7	3	4	4	
		10.3	24.1	24.1	10.3	13.8	13.8	3.
		20.0	26.9	25.9	11.1	21.1	20.0	5.
		2.0	4.6	4.6	2.0	2.6	2.6	3.
A LITTLE	4.	0	1	0	3	1	2	
		0.0	14.3	0.0	42.9	14.3	28.6	0.
		0.0	3.8	0.0	11.1	5.3	10.0	0.
		0.0	0.7	0.0	2.0	0.7	1.3	0.
NONE	5.	0	1	0	0	0	0	
		0.0	100.0	0.0	0.0	0.0	0.0	0.
		0.0	3.8	0.0	0.0	0.0	0.0	0.
		0.0	0.7	0.0	0.0	0.0	0.0	0.
DON'T KNOW	6.	0	1	0	2	1	0	
		0.0	25.0	0.0	50.0	25.0	0.0	0.
		0.0	3.8	0.0	7.4	5.3	0.0	0.
		0.0	0.7	0.0	1.3	0.7	0.0	0.
NOT APPL	7.	0	0	0	0	0	1	
		0.0	0.0	0.0	0.0	0.0	100.0	0.
		0.0	0.0	0.0	0.0	0.0	5.0	0.
		0.0	0.0	0.0	0.0	0.0	0.7	0.
COLUMN TOTAL		15	26	26	27	19	20	17
		9.9	17.2	17.2	17.9	12.6	13.2	11.3

The findings here are that the community leaders perceive themselves to be somewhat more supportive and cooperative than do the directors, staff, and parents. Schematically the comparison looks like this:

Table D39. Support/Cooperation of Community Leaders

Categories of Response	Directors, Staff, Parents (n=428)		Community Leaders (n=151)	
	Number	Percent	Number	Percent
A Great Deal	130	30.4	61	40.4
Quite a Bit	132	30.8	48	31.8
(Above two combined)	(262)	(61.2)	(109)	(72.2)
Some	95	22.2	29	19.2
(First three combined)	(357)	(83.4)	(138)	(91.4)
A Little	38	8.9	7	4.6
None	9	2.1	1	0.7
Don't Know	23	5.4	4	2.6
Not Applicable	1	0.2	1	0.7

What this shows is that whereas 61.2% of the directors, staff and parents rated the support and cooperation of community leaders as either "a great deal" or "quite a bit," 72.2% of the leaders themselves gave such answers, suggesting that, the leaders have a somewhat more positive rating of their worth as supporters and cooperators with their H.S. program than do the directors, staff and parents.

Actually however this difference of degree of perception of worth is no doubt less important than the fact that all of these respondents seem to have expressed a strong concensus as to how supportive and cooperative the community leaders are.

The community leaders who were interviewed then were asked if they were directly involved in any activities of their local Head Start program. Their answers are presented in Table D40, following this page.

This data lends strength to that gathered from the directors, staff, and parents regarding the support and cooperation they feel H.S. programs get from their local community leaders. Eighty-seven percent (86.8%) of the leaders answered in the affirmative about involvement with the Head Start T/TA activity, which indicates a very high level of involvement, at least according to these particular respondents.

A further guage of the involvement of these community leaders, besides their own testimony about whether or not they participate in T/TA activities, can be had from examining the answers they gave when asked - as a follow up question - how familiar they were with the T/TA provided to the staff or parents of the local Head Start program. Ninety-three percent (93.2%) said they were at least somewhat familiar. All their answers break out this way:

Responses	Number/Percent
Very familiar	53/32.7%
Somewhat familiar	98/60.5%
Not at all familiar	11/ 6.8%
	162/100.0%

No respondents in either Region II, New York, or Region VI, Dallas, said they were not at all familiar - indicating that community leaders in those two case studies apparently are more familiar with T/TA activity.

Table D40. Involvement of Community Leaders in T/TA (n=162)

ACTINVHS	RGN	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
		2.1	3.1	4.1	5.1	6.1	10.1	11.1	
1. YES	COUNT	15	22	20	24	15	20	15	131
	ROW PCT	11.5	16.8	15.3	18.3	11.5	15.3	11.5	80.9
	COL PCT	100.0	84.6	74.1	88.9	78.9	100.0	88.2	
	TOT PCT	9.9	14.6	13.2	15.9	9.9	13.2	9.9	
2. NO	COUNT	0	4	7	3	4	0	2	20
	ROW PCT	0.0	20.0	35.0	15.0	20.0	0.0	10.0	13.2
	COL PCT	0.0	15.4	25.9	11.1	21.1	0.0	11.8	
	TOT PCT	0.0	2.6	4.6	2.0	2.6	0.0	1.3	
COLUMN TOTAL		15	26	27	27	19	20	17	151
		9.9	17.2	17.9	17.9	12.6	13.2	11.3	100.0

The community leaders were then queried about the capacity in which they got involved in T/TA activities. For example, was it as a member of the Grantee Board or the Policy Advisory Council (PAC), or was it as a member of some community agency, etc.? The answers to this query are displayed here in Table D41.

Table D41. Capacity of Community Leaders In T/TA Involvement (C.L. n=162)

REGN / COUNT / ROW PCT / COL PCT	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN
	2.0	3.0	4.0	5.0	6.0	10.0	
1. GRANTEE AGCY	1	7	3	1	3	3	
	6.7	46.7	0.0	6.7	20.0	20.0	0.0
	6.7	31.8	0.0	4.2	20.0	15.0	0.0
	0.6	4.3	0.0	0.6	1.9	1.9	0.0
2. GRANTEE BOARD	1	0	1	2	0	0	4
	12.5	0.0	12.5	25.0	0.0	0.0	50.0
	6.7	0.0	5.0	8.3	0.0	0.0	26.7
	0.6	0.0	0.6	1.2	0.0	0.0	2.5
3. POLICY ADV CNCL	6	5	7	9	4	4	5
	15.0	12.5	17.5	22.5	10.0	10.0	12.5
	40.0	22.7	35.0	37.5	26.7	20.0	33.3
	3.7	3.1	4.3	5.6	2.5	2.5	3.1
4. COMMUNITY AGCY	5	7	8	5	4	2	5
	15.2	21.2	24.2	15.2	12.1	6.1	15.2
	33.3	31.8	40.0	20.8	26.7	10.0	33.3
	3.1	4.3	4.9	3.1	2.5	1.2	3.1
5. OTHER	1	1	3	6	3	8	
	4.5	4.5	13.6	27.3	13.6	36.4	0.0
	6.7	4.5	15.0	25.0	20.0	40.0	0.0
	0.6	0.6	1.9	3.7	1.9	4.9	0.0
6. COMBINATION	1	2	4	1	1	3	1
	7.7	15.4	30.8	7.7	7.7	23.1	7.7
	6.7	9.1	20.0	4.2	6.7	15.0	6.7
	0.6	1.2	2.5	0.6	0.6	1.9	0.6
COLUMN TOTAL	15	22	20	24	15	20	10
	9.3	13.6	12.3	14.8	9.3	12.3	6.2

This data shows that nearly one-third of the involved community leaders (30.5%) participate as members of the Policy Advisory Council and that another 17.6% serve on the Grantee Board or for the Grantee Agency in some other way. All told, then, nearly one-half (48.3%) of the community leaders apparently have some official connection with their local program. One-fourth (25.2%) represent one community agency or another.

At this point these community leaders were asked to indicate the nature of the T/TA activities in which they generally get involved. Listed here are the specific categories of activity and the corresponding frequency of response from the leaders:

Category of activity	Frequency of response (n=162)
1. Program development	71/43.8%
2. Education services	63/38.9%
3. Health services	55/34.0%
4. Family services	54/33.3%
5. Materials/supplies	41/25.3%
6. Financial support	31/19.1%
7. Other	35/21.6%

Then as a follow-up question, each community leader was asked specifically what assistance, services, resources, or information he or she provided to the Head Start program. They could mention up

to three items. The results of this question are given here in Table 042.

Table 042. Specific Activities of Community Leaders (C.L. n=162)

Specific Activity	Frequency of response
1. administrative services	7s
2. fiscal management	11s
3. supervision of grantee	12s
4. program development	13s
5. curriculum development	7s
6. social services (family)	15s
7. eligibility determination	4s
8. coordination of public and private services	9s
9. recruitment of consultants	3s
10. health services	24s
11. referrals	8s
12. teacher training	7s
13. assistance to staff	6s
14. assistance to parents/parent involvement	15s
15. outreach	3s
16. materials (a-r, written)	8s
17. financial aid	3s
18. transportation	3s
19. facilities	14s
20. support services (secretarial, etc.)	6s
21. general advice	24s
22. T&TA	12s
23. mental health/psych services	2s
24. handicapped progs	4s
25. behavioral problems	1s
26. other such as leadership training	17s
27. diagnosis/screening	12s

Clustering several categories of responses facilitates the understanding of the of their importance. For example, a number of them constitute what could be considered general T/TA:

(9)	recruitment of consultants	3	responses
(12)	teacher training	7	"
(13)	assistance to staff	6	"
(14)	assistance to parents/p.i.	15	"
(16)	materials (a-v, written)	8	"
(21)	general advice	24	"
(22)	T/TA	12	"
		75	responses

A number of them relate to health and therefore could also be clumped together:

(10)	health services	24	responses
(23)	mental health/psych svcs.	2	"
(24)	handicapped	4	"
(25)	behavioral problems	1	"
(27)	diagnosis/screening	12	"
		43	responses

Similarly, several categories of specific responses regarding support services seem closely related:

(7)	eligibility determination	4	responses
(11)	referrals	8	"
(15)	outreach	5	"
(17)	financial aid	3	"
(18)	transportation	3	"
(19)	facilities	14	"
(20)	support (secretarial, etc.)	4	"
		41	responses

Several specific categories relating to overall administration could also be combined.

(1)	administrative services	7 responses
(2)	fiscal management	11 "
(3)	grantee supervision	12 "
		30 responses

A couple of items coalesce under the umbrella concept of social services (general):

(6)	social services (family)	15 responses
(8)	coordination of public and private services	9 "
		24 responses

Also, a couple of categories cluster under the general topic of development:

(4)	program development	13 responses
(5)	curriculum	7 "
		20 responses

Lastly, the other responses include:

(26)	other, such as leadership training	17 responses

These clusters of categories help in explaining the specific areas of activity in which the various community leaders are engaged.

Next the 428 directors, staff, and parents were asked, in regard to the services offered by their program, how supportive and cooperative they thought the parents were (e.g., volunteering to help with projects). They were given the same five point scale on which to answer: "a great deal, quite a bit, some, a little, none." Their answers are presented in Table D43, following this page.

The findings in this table must be approached in light of the fact that parents also are answering the question - their responses have been combined here with those of the directors and staff, as has been the case throughout this chapter. The percentage of respondents reporting that parents supported and cooperated with them at least "quite a bit" is 52.5% (the comparable figure regarding community leaders was 61.2%). 81.2% said they received, at a minimum, "some" support and cooperation (83.4% was the corresponding figure for the community leaders). Just over sixteen percent (16.1%) percent said they got only a little support and cooperation; a scant 0.9% (4 persons out of 428) reported no support or cooperation from parents.

The data seems to warrant a conclusion that Head Start programs are receiving substantial support and cooperation from the parents of enrolled children, even when it is granted that many of the respondents (160 to be exact) are themselves parents.

As far as regional differences are concerned on this subject of support and cooperation given by parents to local programs, Region II (New York) respondents exceeded the "normal" (52.5%) frequency of "a great deal" and "quite a bit" responses to this question - their frequency of response was 68.8%, far greater than any of the other 6 regions. Region X (Seattle) interviewees answered "a great deal" or "quite a bit" only 30.8% of the time, way below both the

Table D43 Support, Cooperation of Parents (DSP n=428)

PARENTSP RATE SUPPORT OF PARENTS BY REGION

REGION

PARENTSP	COUNT / ROW PCT / COL PCT / TOT PCT	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
A GREAT DEAL	20.	14	21	[illegible]	[illegible]	11	[illegible]	[illegible]	[illegible]
		[illegible]	21.9	[illegible]	16.7	[illegible]	[illegible]	[illegible]	[illegible]
		[illegible]	26.9	[illegible]	25.4	[illegible]	[illegible]	[illegible]	
		[illegible]	4.9	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
QUITE A BIT	21.	19	20	21	[illegible]	16	[illegible]	[illegible]	[illegible]
		14.7	15.5	[illegible]	17.1	[illegible]	[illegible]	[illegible]	[illegible]
		39.6	25.6	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
SOME	22.	12	21	17	[illegible]	16	[illegible]	[illegible]	[illegible]
		[illegible]	17.4	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		25.6	26.9	[illegible]	20.6	[illegible]	[illegible]	[illegible]	
		[illegible]	4.9	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
A LITTLE	23.	[illegible]	12	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		4.3	17.4	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		[illegible]	15.4	[illegible]	[illegible]	17.3	[illegible]	[illegible]	
		[illegible]	2.8	[illegible]	1.4	[illegible]	[illegible]	[illegible]	
NONE	24.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
		.5	.0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
DON'T KNOW	88.	0	4	[illegible]	1	[illegible]	[illegible]	[illegible]	[illegible]
		[illegible]	57.1	20.0	14.3	[illegible]	[illegible]	[illegible]	[illegible]
		[illegible]	5.1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	COLUMN TOTAL	[illegible]	78	71	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

"norm" of 52.5% and all other individual case study regions. The conclusion suggested is that Region II interviewees tend to feel more positive about contributions from parents than respondents in the other 6 case studies and Region X persons interviewed tend to feel less positive about parents' contributions than those in the other regions. Recall that Seattle respondents also seemed to register the least positive feedback of any of the case study respondents on the support and cooperation received from community leaders.

This same question, (i.e., in regard to the services offered by the local Head Start program, how supportive and cooperative are the parents?) was also asked of the community leaders. Their answers are given in Table D44, following this page.

Again, the main finding is that an essentially favorable rating has been given by community leaders regarding the support and cooperation they perceive as being given by parents in terms of T/TA activities. Fifty-six percent (56.3%) said the parents contributed "a great deal" or "quite a bit" and 88.8% said the parents rendered at least "some" support and cooperation.

Note that again, the community leaders tend to give more glowing responses than do directors, staff and parents regarding support and cooperation from the parents. This was also the case on the question about support and cooperation from the community leaders themselves. However, the variation in perception of the worth of parents and community leaders which was reported through self-appraisal as opposed to that reported by directors and staff is of only minor significance. The essential finding which was emphasized earlier, is that all these people demonstrate a consistently high regard for one another. This positive factor continually surfaces and can not help but ultimately strengthen Head Start program and result in better services at the local level.

ERIC

Table D44. Support, Cooperation of Parents (CL n=162)

CROSSTABULATION OF:
PTSCPWHS PARENTS COOPERATION WITH HEAD START BY RGN REGION

PTSCPWHS	RGN	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	COUNT	2.1	4.1	4.1	5.1	6.1	10.1	11.1	
	ROW PCT								
	COL PCT								
	TOT PCT								
1. A GREAT DEAL		8	5	3	6	5	4		31
		19.5	12.2	7.3	14.6	12.2	9.8	24.4	19.1
		53.3	19.2	27.3	22.2	26.3	20.0	41.2	
		5.3	3.1	1.9	3.7	3.1	2.5	5.0	
2. QUITE A BIT		5	15	19	9	2	7	4	61
		8.2	24.6	31.1	14.8	3.3	11.5	6.6	37.7
		33.3	57.7	51.4	33.3	10.5	35.0	23.5	
		3.1	9.3	11.8	5.6	1.2	4.3	2.5	
3. SOME		2	13	4	9	4	6	7	45
		4.4	28.9	8.9	20.0	8.9	13.3	15.6	27.8
		13.3	50.0	10.8	33.3	21.1	30.0	41.2	
		1.2	8.0	2.5	5.6	2.5	3.7	4.3	
4. A LITTLE		0	1	1	1	1	0	1	5
		0.0	20.0	20.0	20.0	20.0	0.0	20.0	3.1
		0.0	3.8	2.7	3.7	5.3	0.0	5.9	
		0.0	0.7	0.7	0.7	0.7	0.0	0.7	
6. DONT KNW		1	2	0	2	3	1	0	9
		11.1	22.2	0.0	22.2	33.3	11.1	0.0	5.6
		6.7	7.7	0.0	7.4	15.8	5.0	0.0	
		0.7	1.2	0.0	1.2	1.9	0.7	0.0	
7. NOT APPL		0	0	0	0	0	2	0	2
		0.0	0.0	0.0	0.0	0.0	100.0	0.0	1.2
		0.0	0.0	0.0	0.0	0.0	10.0	0.0	
		0.0	0.0	0.0	0.0	0.0	1.2	0.0	
COLUMN TOTAL		15	26	27	27	19	20	17	161
		9.9	17.2	17.9	17.9	12.6	13.2	11.3	100.0

Regional variations show up in this data. Region IV Atlanta respondents answered "a great deal" or "quite a bit" 81.5% of the time, more frequently than any other region's respondents and more than the "normal" frequency of these responses of 56.3%. Region X Seattle (75.0%) and Region II New York (73.3%) also ranked very high in giving such positive answers about the support and cooperation of parents.

A second form of analysis of the data described in this section regarding the extent of community leader (Table D37) and parent (Table D43) support was implemented through a cross-tabulation of these results with the data obtained on both the level of satisfaction with T/TA and the extent of T/TA impact as perceived by these same respondents, i.e., all 428 directors, staff, and parents.

Table D45 displays the joint frequency distribution of cases involving extent of support from community leaders and parents and the satisfaction level with T/TA

As regards support from community leaders, it can be seen that, as the perceived extent of support declines, so the percent who indicated satisfaction level as "very satisfied" also declines. Among those who were "dissatisfied/very dissatisfied", the percentage rises as perceived extent of support declines.

As regards extent of support from parents, no notable patterns emerge.

Table D45 Cross-Tabulation of Extent of Support from Community Leaders and Parents with Satisfaction Level with T/TA Provided to Local Program (DSP)

Extent of Support from Each Group	Percent Indicating Level of T/TA Satisfaction and Extent of Support from Each Group			Total Percent Indicating Extent of Support from each Group
	Very Satisfied	Satisfied	Dissatisfied/ Very Dissatisfied	
Community Leaders				(n=389)
A Great Deal	41.3	46.8	11.9	32.4
Quite a Bit	34.6	53.1	12.3	33.4
Some	25.6	57.8	16.7	23.1
A Little/None	18.6	53.5	27.9	11.1
Parents				(n=404)
A Great Deal	37.2	50.0	12.8	29.3
Quite a Bit	31.2	54.4	14.4	30.9
Some	34.7	50.0	15.3	29.2
A Little/None	26.9	58.2	14.9	16.6

Note: The percents listed in the right-hand column are based on a varying number of respondents, as indicated. All don't know and not applicable responses have been omitted.

Table D46 Cross-Tabulation of Extent of Support from Community Leaders and Parents with Extent of Impact from T/TA Provided to Local Program (DSP)

Extent of Support from each group	Percent Indicating Extent of T/TA Impact and Extent of Support from Each Group				Total Percent of Indicating Extent of Support from Each Group
	A Great Deal	Quite a Bit	Some	A Little/None	
Community Leaders					(n=383)
A Great Deal	46.3	28.5	17.9	7.3	32.1
Quite a Bit	30.5	32.8	29.7	7.0	33.4
Some	23.6	30.3	36.0	10.1	23.2
A Little/None	18.6	27.9	34.9	18.6	11.2
Parents					(n-393)
A Great Deal	37.6	33.3	23.7	5.4	23.7
Quite a Bit	24.4	36.6	30.9	8.1	31.3
Some	34.8	29.5	25.0	10.7	28.5
A Little/None	38.5	18.5	32.3	10.8	16.5

Note: The percents listed in the right-hand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

Table D46 displays the joint frequency distribution of cases involving extent of support from community leaders and parents and the perceived impact of T/TA.

Looking here at extent of support from both groups and overall T/TA impact, a similar pattern emerges to that seen in the previous Table D46. For community leaders, the percent indicating greatest extent of support is highest for greatest extent of T/TA impact (a great deal 46.3%) and declines as perceived extent of community leader support decreases. Conversely, as extent of support decreases, the percent indicating the least T/TA impact (a little/none) rises.

No particular patterns are revealed as regards extent of support from parents.

In summary:

- The greater the extent of perceived support from the community leaders, the higher the percentages in the optimal categories for both T/TA satisfaction and impact.
- The lesser the extent of perceived support from community leaders, the higher the percentages for the minimal categories of T/TA satisfaction and impact.
- Extent of parent support reveals no notable patterns for either T/TA satisfaction or impact.

Summation of D3 Findings: Other Supportive Resources Utilized

The question addressed in this section was "how effectively are other supportive resources being utilized?". The focus was on local community personnel, services, materials, or equipment that were donated to local programs sampled. Parents were also considered in this section, in their role as "supportive resources." Only local program people, as well as community leaders, were interviewed on this topic.

Regarding how supportive and cooperative community leaders are with local programs, 6 out of 10 directors, staff, and parents and 7 out of 10 of the leaders themselves (See Table D39) rated their support and cooperation very highly, i.e., "a great deal" or "quite a bit." This indicates a strong consensus among all local level interviewees regarding how helpful the community leaders are. Nearly one-half of the leaders surveyed reported some official connection (See Table D41) with their local Head Start -- this phenomenon tends to confirm the finding that they tend to be very helpful toward the local programs. The areas in which they tended to offer help most frequently were a) general T/TA, b) health, c) support services, e.g. facilities, transportation, d) administration, e) social services, and f) development. Table D42 and its subsequent elaboration presented a detailed breakout of this item.

Regarding how supportive and cooperative parents are with local programs 52.5% of the local program people (i.e. directors, staff, and the parents themselves) and 56.3% of the community leaders interviewed rated their support and cooperation very highly, i.e., "a great deal" or "quite a bit." This data, while not as overwhelming as that reported above regarding the community leaders, suggests that local H.S. programs are receiving substantial help from the parents of enrolled children.

Cross-tabulation of all these findings with other data on overall satisfaction (see Section E1) and perceived impact of T/TA (see Section E2) revealed some notable relationships:

- the more help respondents (directors, staff, and parents) report getting from community leaders, the more highly they rated their own

satisfaction and perceived impact of T/TA

- conversely, the less help the respondents reported receiving from the leaders, the less highly they rated their own satisfaction and perceived impact of T/TA
- no such inter-relationships could be seen with the comparable data on parents.

In general, then, local Head Start programs sampled seem to be enormously successful in utilizing other, supportive resources from the local community to augment the T/TA services they receive from national, regional, and local providers. Local programs are still capitalizing on the local institutions which, as reported in KAI's 1970 Summary of A National Survey on the Impacts of Head Start Centers on Community Institutions "have become concerned with the needs and the problems of the poor."

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION D4: How equitably is T/TA distributed among target groups?

Another major indicator of the way Head Start T/TA is being delivered is the amount of service being given to the various target or consumer groups. For example, is enough T/TA being given to the parents, as opposed to that staff? And among staff, is enough available to professionals as well as non- or paraprofessionals? It is questions such as these that will be addressed in this section.

This topic of target groups will be discussed at the national, regional, and local levels.

a. National Level Responses

National level responses on this topic and all other succeeding topics in this chapter, are discussed first from the viewpoint of OCD Headquarters officials and then from that of national T/TA providers.

1. OCD Headquarters Responses

Of the 24 national Head Start staff interviewed 17 could not comfortably give an estimate of the percentage of total T/TA services that were given to four identified general target groups--professionals, paraprofessionals, support staff, and parents--at the local level.

The average of the estimates of the seven respondents are as follows:

Table D47. National Officials Perceptions of Percentages of T/TA to Target Groups (n=7/24)

Professional Staff	35.3%
Paraprofessional Staff	33.7
Support Staff	10.0
Parents	21.0
Total	100.0%

Considering the comparative amounts of T/TA given to professional staff and non-professionals (grouping paraprofessionals, support staff, and parents) the average estimates of respondents were as follows:

Professional staff	35.3%
Non-professionals	64.7%

Certainly a relevant dimension of the consideration of the delivery of T/TA services to target/consumer groups is the question as to whether the delivered services were based upon information/data derived from actual needs assessment processes. Once again the majority of Headquarters staff (18 persons) could not respond to this inquiry. Of the six who were able to respond, three said "Yes" definitively, and three gave qualified "Yes" responses; the qualification in these cases was expressed in the belief that the delivered service did address actual needs but possibly was not based upon a formal needs assessment process.

2. National Provider Responses

Of primary concern in the delivery of T/TA is who should be the recipients and how much is needed for each group of people. We asked national providers to indicate how much T/TA each category of people

should receive and to name any other groups they felt should be included in T/TA activities. Table D48 arrays the data from this question.

Table D48. T/TA Requirements by Target Groups: National Providers (n=34)

Target Group*	Percent of National Providers Specifying Amount of T/TA Required				
	More	Same	Less	Don't Know	Not Applicable
Administrators	67.6	17.6	--	2.9	11.8
Coordinators	70.6	11.8	--	2.9	14.7
Teachers	64.7	20.6	--	--	14.7
Aides	64.7	14.7	--	2.9	17.6
Support Staff	58.8	17.6	--	5.9	17.6
Parents	70.6	2.9	--	8.8	17.6
Other	8.8	--	--	--	91.2

*Note the first four categories were refined from those used with the OCD Headquarters officials in order to get more specificity.

It is apparent immediately that the majority of providers felt each category shown above should receive more T/TA. No one said less for any group. Most providers named coordinators and parents requiring more T/TA, followed closely by administrators. Support staff was the group named least often by providers as needing more T/TA (except for other, which included groups such as private practitioners in direct care services, cooks in agencies, national contractors, and the general community).

The range of percentage indicating more T/TA required is very narrow--about a 12% spread, which shows high unanimity among providers. The expression by most providers that more parent T/TA should be given correlates with the earlier finding that parent involvement T/TA was one of the most

frequently mentioned types of T/TA given in Fiscal Year 1975 by national providers (Table D8). T/TA to parents is seen as a priority, and among our sample of national providers responsiveness to that priority is evident.

Among those providers who said the same amount of T/TA that has been given should continue, the group named most often was teachers, the group named least often, parents.

b. Regional Level Responses

Regional Level responses on this topic of T/TA target groups, and all other succeeding topics in this chapter, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1. Regional Office Responses

These responses are further divided into two parts: an integrated analysis of responses from all 11 regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter.

a). Aggregated analysis of all 11 regions

(See Chapter II for an explanation of the selection process for interviewees in the Regional Offices.)

Of the 64 regional office interviewees, 23 were unable to give observations on the percentage of total T/TA service given to the identi-

fied four target groups. Averaged estimates from the 41 respondents are as follows:

Table D49. Regional Office Perceptions of Percentages of T/TA to Target Groups (n=41/64)

Professionals	38.4%
Paraprofessionals	29.3
Support Staff	9.3
Parents	23.0
Total	100.0%

NOTE: Compare this Table to Table D47 on National Office perceptions.

Further comparison between averaged estimates of T/TA service given to professional versus non-professional personnel yields the following results:

Professional staff	38.4%
Non-professionals	61.6
	100.0%

Regional Office staff were also asked to give their opinion as to whether the T/TA service given across target groups was actually based upon data derived from needs assessment procedures. Of the 25 respondents to this question, 15 replied affirmatively and 10 said they did not believe that T/TA was delivered on the basis of needs assessment activities.

Finally on this subject, Regional Office staff were asked to rank (on a scale of High-Medium-Low) the overall need for T/TA service on the part of each of the four target groups. The responses to this item were evenly divided in the "High" and "Medium" categories with no group being perceived as having "Low" general need for T/TA services.

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study" Regional Office on the topic of T/TA target groups. (See Chapter II for an explanation about the selection of the "case studies.")

New York (II)

The distribution of T/TA services to consumer or target groups is perceived as follows:

Professional Personnel	45%
Non-Professional Personnel (Including paraprofessionals, support staff, and parents)	55%

Of the total amount of T/TA given in Region II it was estimated that parents were allocated approximately 25%.

Finally, Region II personnel appear to recognize the need for T/TA in fiscal and other management areas in local programs throughout the region. A further observation is that of the need for T/TA for part-time and other personnel who do not have the backgrounds required for some jobs they are required to perform.

PHILADELPHIA (III)

Regional Office staff estimated the following averaged percentages of T/TA being given to the four target groups:

Professionals	45%
Paraprofessionals	22%
Support Staff	11%
Parents	22%
	100%

The quality of the T/TA process was rated at "Excellent," "Very Good," and "Good" for all target groups except for paraprofessionals; for this group Regional Office personnel evenly divided their estimates between "Very Good" and "Fair."

All respondents from Region III did perceive the T/TA activities as addressing specific content areas as identified through a needs assessment process. Likewise, all respondents except one ranked the general need for T/TA service by the target groups as being "High."

ATLANTA (IV)

Regional Office staff identified their estimates of T/TA service given to the four target groups as follows:

Professionals	34%
Paraprofessionals	26%
Support staff	14%
Parents	26%
	100%

Inquiry was also made as to the quality of the T/TA delivery process for each group on a scale consisting of Excellent/Very Good/Good/Fair/Poor. Virtually all respondents ranked the process for each group at the levels of "Excellent," "Very Good," and "Good." Two respondents rated the process for support staff and parents as "Fair."

Inquiry was also made of relevant regional personnel as to whether the delivered T/TA services did meet the actual local needs. The consensus was to affirm generally that services did address known local needs. However, one respondent succinctly articulated one factor that may interfere with this process. In the elapsed time between the identification of local needs and the delivery of T/TA service, it is not unusual to experience significant turnover in the membership of the

consumer groups--particularly in non-professional personnel. Thus, in the turnover of personnel it is likely that differential T/TA needs are presented.

On a scale of High-Medium-Low, Region IV personnel were asked to rank the need for T/TA services in each of the four consumer groups given above. For all groups the need was ranked as "High" and "Medium" by all respondents. The relatively high turnover rates in some groups, as expected, tends to heighten the needs level.

CHICAGO (V)

According to data from Region V, the paraprofessional staff received the most training services, estimated to be 46%, with a judgment of "Good" to "Very Good" for effectiveness. The parents received 30.5% of all training services, and the effectiveness was also judged to be "Good" to "Very Good." The professional staff received the rest of the training services, 23.5% with the conflicting effectiveness ratings of "Fair" and "Excellent." According to Region V data, the support staff received such scant training that no real percentage could be assigned to it.

Technical assistance services, in contrast, went largely to the professional staff, 47.5%, with a "Good" to "Very Good" rating for effectiveness. 27.5% of TA services went to parents with a "Good" rating, and 22.5% of TA services went to paraprofessional staff and was judged "Good." Support staff received 2.5% of TA services, and thus was judged "Fair" to "Poor" for effectiveness.

Respondents in Region V saw the definition of actual local needs as the biggest problem in getting providers to respond effectively, but did feel that when these needs were clearly defined, individualized T/TA needs were provided.

The level of need for T/TA services in Region V by professional staff and support staff was judged to be "High," while parents' level of need was "Medium" to "High," and that of paraprofessional staff, mainly teachers, was judged to be "Medium."

DALLAS (VI)

Regional Office personnel estimated the following averaged percentages of T/TA given to four identified target groups:

Professionals	52.5%
Paraprofessionals	27.5%
Support staff	9.0%
Parents	11.0%
	100.0%

T/TA delivery processes for each target group tended to be rated "Excellent," "Very Good," and "Good." However, some observation was expressed that the process for support staff and parents was "Fair" and "Poor."

There are conflicting responses in Region VI as to whether or not local needs were actually met by the T/TA given. Of two out of six respondents, one said needs were met and one said local program needs were not met by the T/TA provided.

In Region VI, parents and paraprofessional staff were judged to have a "High" level of need for T/TA services (by 2 out of 6 respondents), while professional staff and support staff were given a "Medium" to "High" level of need.

SEATTLE (X)

Data from Region X indicates that the majority of training goes to the professional staff, with the average percentage given at about

55%. The next largest percentage of training went to the paraprofessional staff (avg. 25%), the parents received about 15% of the training services offered, and the support staff only a small fraction (5%). The effectiveness of these services was rated as "Good" to "Very Good."

Technical assistance services went primarily to the professional staff, with an average of 60% as noted by respondents. There is a difference of opinion among respondents as to which group received the next largest amount of TA, half judging the paraprofessional staff as getting a larger percentage (25-30%) and half judging this amount to parents. All agree that technical assistance to the support staff is very small (5% if any). The effectiveness of TA given to each group is rated generally as "Good" by respondents in Region X.

The feeling in Region X is that too much T/TA services are provided to the professional, educated staff; and this falls short of meeting actual needs. More T/TA needs to go to the support staff which, most respondents agree, get shortchanged. Also more T/TA to parents and paraprofessionals is desired, and one respondent would like to see volunteers benefit from T/TA.

The level of need for T/TA for professional staff, paraprofessional staff, and support staff was seen as either "Medium" or "High" by all respondents in Region X. Only the parents were unanimously seen as having a "High" level of need of T/TA.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

IMPD staff estimated the allocation of T/TA activities in the following fashion:

Professionals	40%
Paraprofessionals	33%
Support staff	9%
Parents	18%
	100%

All respondents except one perceived the T/TA delivery process to be "Excellent," "Very Good," or "Good" for all target groups. The single respondent saw the T/TA process for support staff to be "Poor," and for parents, "Fair."

The paraprofessional staff and parents were seen as having the highest level of need in the IMPD region, with professional staff and support staff judged as having a "Medium" to "High" level of need.

2. Regional Provider Responses

Presented in this section is an analysis of the responses received from the 77 regional providers interviewed (group two) on the subject of T/TA target groups. None of the RTO/STO network (group one) providers were interviewed on this topic. Regional variations in these data will be highlighted as appropriate.

Like regional office staff, regional providers were also asked about the groups who receive T/TA and the amount of T/TA needed for each. We asked the providers, "For each category of people I name, do you think there should be more, less, or about the same amount of

T/TA available as there is currently?" Table D50 presents the distribution of responses:

Table D50. T/TA Requirements by Target Groups: Regional Providers (n=77)

Target Groups*	Percent of Regional Providers Specifying Amount of T/TA Required				
	More	Same	Less	Don't Know	Not Applicable
Administrators	59.7	32.5	3.9	2.6	1.3
Coordinators	54.5	37.7	2.6	2.6	2.6
Teachers	62.3	31.2	--	5.2	1.3
Aides	74.0	19.5	--	5.2	1.3
Support Staff	66.2	23.4	1.3	6.5	2.6
Parents	88.3	7.8	--	2.6	1.3
Other	41.6	3.9	--	--	54.5

*Note the first four categories were refined from those used with the RO officials (see Table D49) in order to get more specificity.

NOTE: Compare this Table with Table D48 (National Providers).

For each category of people, the majority of providers said more T/TA is required. There is, however, a wider variation among the groups needing more as compared to national provider responses to this same question (see Table D48). Most regional providers viewed parents as the group most needing more T/TA (88.3%). The group providers named next most often was aides (74.0%). Support staff and teachers came next, followed by administrators and coordinators. It may be that these groups were the focus of T/TA activity already (notice that the percentages of providers indicating administrators, coordinators, and teachers should receive the same amount of T/TA range across the third decile, and that for administrators, coordinators, and support staff a few providers said

less T/TA is needed). Regional providers expressed a nearly unanimous concern about more parent T/TA needed, and it has been translated into action as revealed by the fact that parent involvement T/TA was one of the most frequently named categories of T/TA offered in Fiscal Years 1974 and 1975 (see Table D17).

Before leaving the discussion of these aggregated responses, note that many providers mentioned "other" categories (41.6%). A variety of groups were named, but most often mentioned was volunteers (16.9% of all providers), followed by T/TA providers/consultants and community services (e.g., handicapped, psychological, 9.1%), grantee or delegate agency administrators and boards (7.8%), policy councils and the local community political structure (each 6.5%). Other responses with a frequency of three to one respondents were staff people such as cooks, maintenance personnel, bus drivers, and education workers.

Few providers answered don't know or not applicable for all categories of people (except other). The percentage answering "Not Applicable" was smaller than for national providers, which points up primarily that regional providers were more intimately involved than national providers with T/TA at the local levels. Other differences between the two provider groups are that a higher percentage of national providers than regional felt more T/TA was needed for administrators (67.6% vs. 59.7%), coordinators (70.6% vs. 54.5%), and teachers (64.7% vs. 62.3%), but a lower percentage of national than regional providers thought more T/TA was required for aides (64.7% vs. 74.0%), support staff (58.8% vs. 66.2%), and parents (70.6% vs. 88.3%). Both groups, however, responded most frequently that, of all categories of people, parents needed more T/TA.

Regional variations among providers appear for several categories of people named:

- For administrators, the "norm" for all providers who indicated more T/TA is required was 59.7%. Region II (New York) was lower (25.0%) as was Region X (Seattle) (0.0%). Regions IV (Atlanta, V (Chicago), and XI (IMPD) were all higher (77.8%, 87.5%, and 80.0% respectively). Most providers in those regions that were lower on this norm, II and X, felt the amount of T/TA being given to administrators should stay the same. The "norm" for same was 32.5%, compared to 75.0% of providers in Region II and 100.0% in Region X who said same. Few providers in Regions IV, V, and XI said same (16.7%, 0.0%, and 20.0% respectively).

- For coordinators, the "norm" for all providers who wanted more T/TA was 54.5%. Regions II and XI providers were higher (75.0% and 80.0% respectively), while Region VI (Dallas) and X were lower (35.7% and 33.3% respectively). Conversely then, fewer providers in Regions II (25.0%) and XI (20.0%) wanted the same amount of T/TA for administrators (the "norm" was 37.7%), while more providers in Regions VI (57.1%) wanted the same amount.

  NOTE: Generally, the pattern obtains that when few providers in a region want more T/TA for a certain category of people, most want the same. When, however, the percentage for a particular region is at or near the "Norm" (with a 10.0% range higher or lower), that does not constitute a regional variation so it is not mentioned. Occasionally, some providers in a region will answer less, or don't know, or not applicable, which then accounts for the total percent of providers interviewed in our sample. Unless the percent is notable, either because it is at variance with the "norm" or constitutes the total percent of all providers giving that answer, it will not be mentioned.

- For teachers, the "norm" for all providers who wanted more T/TA was 62.3%. All of Regions II and XI providers (100.0% each) said more. Half of Regions III and V providers (50.0% each) want more. But only 22.2% of Region X providers said more, while the remainder said same (77.8%), compared to that "norm" of 31.2%.

- For aides the "norm" for all providers who felt more T/TA is needed was 74.0%. Again, Regions II and XI providers were unanimous in wanting more (100.0% each). Regions III (Philadelphia) and V providers fell below the "norm," 57.1% and 62.5% respectively. In Region III, the percentage who said the same amount of T/TA should be given to aides was 35.7, compared to the "norm" of 19.5%. While the percent in Region V who said same was near the norm, 12.5%, 25.0% said don't know.

- For support staff, the "norm" for all providers who wanted more T/TA was 66.2%. Region IV (Atlanta) and XI providers were higher, 83.3% and 80.0% respectively, while Regions V and VI providers were lower, 37.5% and 42.9% respectively. Most of the providers in these latter two regions said same amount of T/TA is needed (V, 50.0%; VI, 42.9%, compared to "norm" of 23.4%).

- For parents, the "norm" for all providers who said more T/TA is required was 88.3%. Regions II and IV providers were unanimous in desiring more (each 100.0%), while fewer Region V providers so indicated (75.0%).

- For other, the "norm" for all providers wanting more T/TA was 41.6%. Regions II and IV providers were much higher (75.0% and 61.1% respectively); Region V and X providers much lower (25.0% and 0.0% respectively).

c. Local Level Respones

Local level responses on this topic of target groups of T/TA, and all other topics in this chapter on findings, are discussed first from the viewpoint of directors staff, parents, and community leaders (where appropriate) associated with the 30 Head Start programs sampled and then from that of local level T/TA providers.

1. Local Program Responses

Project staff interviewed a total of 428 directors, staff, and parents. (See Chapter II for an explanation of the selection process utilized.)

These interviewees were asked if they thought more, less, or the same amount of T/TA should be available for various target groups, including administrators, coordinators, teachers, aides, support staff, parents, and others. The results of their aggregated responses are presented here in Table D51.

Table D51. T/TA Requirements by Target Groups: Directors, Staff, Parents (N=428)

Target Groups	Number and Percent of DSP Respondents Specifying Amount of T/TA Required							
	More		Less		Same		Don't Know	Not Applicable
	#	%	#	%	#	%	%	%
Administrators	231	54.0	10	2.3	114	26.6	15.4	1.6
Coordinators	260	60.7	5	1.2	108	25.2	11.0	1.9
Teachers	309	72.7	2	0.5	91	21.3	5.6	0.5
Aides	331	77.3	5	1.2	71	16.6	4.7	0.2
Support Staff	294	68.7	3	0.7	87	20.3	8.6	1.6
Parents	368	86.0	1	0.2	41	9.6	4.0	0.2
Others	82	19.2	--	--	6	1.4	0.2	79.2

In general, these data show an overwhelming concensus that for all target groups more T/TA should be available. In order of priority, the target groups scored thusly:

1st parents	86.0% frequency of response
2nd aides	77.3% frequency of response
3rd teachers	72.7% frequency of response
4th support staff	68.7% frequency of response
5th coordinators	60.7% frequency of response
6th administrators	54.0% frequency of response

In one way, these data are reassuring in that the ones with seemingly the most program responsibility, i.e., the administrators and coordinators, are the ones with the least need for additional T/TA, in the opinion of these respondents. However, much more apparently needs to be accomplished by means of T/TA in all target groups, including the administrators and coordinators, for whom 54% and 60.7% of the interviewees respectively felt more T/TA was desirable.

Looking at the data for regional differences shows some significant findings (see Table D53). Most startling is the consistency with which Region XI IMPD respondents outnumber respondents in each of the other case study regions with "more T/TA needed" responses for the various target groups. In all target groups but one (parents), they registered the largest percentage of responses for "more" T/TA.

For three of the six target groups (teachers, aides, and support staff), New York respondents registered the second highest regional percentage of "more" answers; and in the only target group that IMPD persons interviewed did not lead with "more T/TA" responses, the parents category, New York respondents were in the forefront, with a 97.9% frequency of response. For administrative, Atlanta respondents also evidence a high percentage of more T/TA needed. Region X Seattle respondents were below the "norm" for administrators, coordinators, and parents, and Region VI Dallas respondents below the "norm" for teachers and aides.

Table D53. Regional Differences re. More T/TA for Target Groups

Region / Group	Percent of Each Region's DSP Respondents Answering "More"							Norm for all seven regions
	II	III	IV	V	VI	X	XI	
Administrators	64.6%	44.9%	66.2%	54.0%	48.1%	32.7%	67.2%	54.0
Coordinators	68.8%	52.6%	69.0%	57.1%	57.7%	47.3%	73.8%	60.7
Teachers	87.5%	67.9%	71.8%	63.5%	59.6%	65.5%	91.8%	72.2
Aides	87.5%	74.4%	74.6%	73.0%	61.5%	78.2%	93.4%	77.3
Support Staff	75.0%	64.1%	67.6%	69.8%	61.5%	65.5%	78.7%	68.7
Parents	97.9%	83.3%	87.3%	81.0%	82.7%	74.5%	96.7%	86.0
Others	25.0%	25.6%	28.2%	7.9%	30.8%	5.5%	9.8%	

A second form of analysis of these data involved the cross tabulation of these results with data obtained on the level of satisfaction with T/TA received by these same respondents, i.e., all 428 directors, staff, and parents (see Section E1). Table D54 arrays the data resulting from this cross tabulation of responses to the question asking the amount of T/TA which should be available to each category of people and the responses to the question seeking satisfaction level with all T/TA provided to the program in the past year. It shows that for four categories of people--administrators, coordinators, teachers, and, to a lesser extent, parents--the percentage of people who were "very satisfied" with their overall T/TA and wanted "more" T/TA for each group was much lower than those respondents who were "very satisfied" and wanted the "same or less" T/TA for each group. Conversely, for each of these groups, the percentage of respondents "dissatisfied/very dissatisfied" and wanting "more" T/TA was somewhat higher than for those respondents "dissatisfied/very dissatisfied" and wanting the "same or less" T/TA.

This data indicates a relationship between amount of T/TA available to administrators, coordinators, teachers, and parents, and overall T/TA satisfaction level. Among those who expressed "more" T/TA should be available for each of these groups, fewer were "very satisfied" and more were "dissatisfied/very dissatisfied" compared to those who felt the "same or less" T/TA should be available. Table D54 follows this page.

Another cross tabulation that seemed appropriate was that with the data on the impact these respondents reported T/TA had on their program. Table D55, shows the amount of T/TA needed for each category of people crossed with extent of T/TA impact on the program. It appears that for four categories of people--coordinators, teachers, parents, and, to a lesser extent, aides--the respondents believing "more" T/TA should be available and that the T/TA impact on their program was "a great deal" and "quite a bit" were a much lower percentage than those in the same impact categories who believed the "same or less" T/TA should be available (coordinators--58.2% vs. 74.5%, teachers--59.7% vs. 73.2%, parents--61.9% vs. 78.1%, and aides--60.9% vs. 74.3%). On the opposite and of the scale, those who wanted "more" T/TA for these groups and rated impact as "some," "a little" or "none" were a much higher percentage than those making the same ratings and desiring the "same or less" T/TA for each group (coordinators--41.7% vs. 25.5%, teachers--40.3% vs. 26.7%, parents--38.1% vs. 21.9%, and aides--39.1% vs. 25.8%).

Thus, comparing those respondents who wanted "more" and those the "same" or "less" T/TA, rougbly three-fifths of the former group felt the T/TA impact was high (a great deal; quite a bit) and two-fifths low (some, a little/none) as opposed to the latter group, three-quarters of whom rated T/TA impact high and one-quarter low for these four categories of T/TA recipients.

Table D54. Cross Tabulation of Amount of T/TA Needed for Each Category of People and Satisfaction Level With T/TA Provided to Local Program (DSP)

Amount of T/TA that Should be Available to Each Category of People	Percent Indicating Level of T/TA Satisfaction and Amount of T/TA that Should Be Available to Each Category of People			Total Percent Wanting More or Same or Less T/TA to Each Category
	Very Satisfied	Satisfied	Dissatisfied/ Very Dissatisfied	
Administrators				(n=347)
More	26.2	55.6	18.2	64.8
Same or Less	43.4	45.9	10.7	35.2
Coordinators				(n=365)
More	26.5	53.8	19.8	69.3
Same or Less	44.6	48.2	7.1	30.7
Teachers				(n=389)
More	29.3	51.7	19.0	77.1
Same or Less	41.6	55.1	3.4	22.9
Aides				(n=392)
More	31.1	51.9	17.0	81.1
Same or Less	36.5	55.4	8.1	18.9
Support Staff				(n=374)
More	31.0	51.2	17.8	76.7
Same or Less	39.1	51.7	9.2	23.3
Parents				(n=395)
More	31.4	52.1	16.4	89.4
Same or Less	45.2	50.0	4.8	10.6
Other				(n=87)
More	30.9	49.4	19.8	93.1
Same or Less	66.7	16.7	16.7	6.9

NOTE: The percents listed in the righthand column are based on varying numbers of respondents as indicated. All Don't Know and Not Applicable responses have been omitted, but exluding the "Other" category of people, the response rate ranges from 81% to 92% of all respondents, so these omitted responses total a relatively small number within our sample.

Table D55. Cross Tabulation of Amount of T/TA Needed for Each Category of People and Extent of Impact from T/TA Provided to Local Program (DSP)

Amount of T/TA that Should be Available to Each Category of People	Percent Indicating Extent of T/TA Impact on Program and Amount of T/TA that Should Be Available to Each Category of People				Total Percent Wanting More or Same or Less T/TA to Each Category
	A Great Deal	Quite a Bit	Some	A Little/ None	
Administrators					(n=339)
More	29.4	30.8	29.9	10.0	65.2
Same or Less	33.1	33.1	24.6	9.3	34.8
Coordinators					(n=359)
More	28.5	29.7	30.5	11.2	69.4
Same or Less	41.8	32.7	18.2	7.3	30.6
Teachers					(n=379)
More	30.7	29.0	28.7	11.6	77.3
Same or Less	33.7	39.5	24.4	2.3	22.7
Aides					(n=382)
More	29.8	31.1	28.2	10.9	81.7
Same or Less	41.4	32.9	22.9	2.9	18.3
Support Staff					(n=365)
More	32.4	27.4	30.6	9.6	77.0
Same or Less	35.7	35.7	20.2	8.3	23.0
Parents					(n=385)
More	30.2	31.7	28.5	9.6	89.4
Same or Less	53.7	24.4	14.6	7.3	10.6
Other					(n=85)
More	25.3	39.2	25.3	10.1	92.9
Same or Less	66.7	0.0	16.7	16.7	7.1

NOTE: The percents listed in the righthand column are based on varying numbers of respondents, as indicated. All Don't Know and Not Applicable responses have been omitted, but, excluding the "Other" category of people, the response rate ranges from 79% to 90% of all respondents, so these omitted responses total a relatively small number within our sample.

To summarize these findings for amount of T/TA needed and overall T/TA satisfaction and impact:

- For coordinators, teachers, and parents an inverse relationship exists between amount of T/TA that should be available and both T/TA satisfaction and impact. The proportion of respondents who indicated "more" was needed and rated T/TA satisfaction and impact high on those scales is smaller than that of respondents who said "same" or "less" T/TA was needed.

- For administrators, the percentage who were "very satisfied" with T/TA overall declined as the amount of T/TA needed moved from "same" or "less" to "more."

- For aides, the percentage who felt overall T/TA impact was "a great deal" declined when amount of T/TA needed was "more" as compared to "same" or "less."

The next query on the topic of target groups for T/TA was about the percentage of staff changeover each year. The question was asked only of the Directors, on the theory that they would best be able to provide the necessary information. The result of this query are shown here in Table D56, following this page.

Two out of three directors (67.7%; 21 of 31) said a maximum of 10% turnover occurs each year. The remaining third of the directors divided their answers between 11% to 20% annual turnover and 21% to 38% annual turnover.

All directors in two regions, IV (Atlanta) and V (Chicago), responded that 10% maximum turnover each year was their experience. Three of four IMPD directors said their staff turnover annually was between 21% and 38%--representing the most directors and the largest percentage of directors in any case study region registering such high turnover rates.

Table D56. Percentage of Annual Staff Turnover

TURNOVER	REGION II (2.1)	REGION III (3.1)	REGION IV (4.1)	REGION V (5.1)	REGION VI (6.1)	REGION X (10.1)	REGION XI (11.1)	ROW TOTAL
1. 1% TO 10%	4	5	4	5	2	0	1	21
	19.0	23.8	19.0	23.8	9.5	0.0	4.8	67.7
	66.7	83.3	100.0	100.0	66.7	0.0	25.0	
	12.9	16.1	12.9	16.1	6.5	0.0	3.2	
2. 11% TO 20%	1	1	0	0	1	2	0	5
	20.0	20.0	0.0	0.0	20.0	40.0	0.0	16.1
	16.7	16.7	0.0	0.0	33.3	66.7	0.0	
	3.2	3.2	0.0	0.0	3.2	6.5	0.0	
3. 21% TO 38%	1	0	0	0	0	1	2	4
	20.0	0.0	0.0	0.0	0.0	20.0	60.0	16.1
	16.7	0.0	0.0	0.0	0.0	33.3	75.0	
	3.2	0.0	0.0	0.0	0.0	3.2	9.7	
COLUMN TOTAL	6	6	4	5	3	3	4	31
	19.4	19.4	12.9	16.1	9.7	9.7	12.9	100.0

As a follow-up question, these same Directors were asked how much repetition of T/TA must be done each year because of their staff turnover rates. They were given five answers from which to choose: "a great deal, quite a bit, some, a little, and none." Their answers to this question are given here in Table D57, following this page.

Nearly four out of ten respondents (39.4%) said 'some' T/TA needed to be repeated, whereas 30.3% reported only "a little" had to be given again. These responses together (23) represent the answers of seven-tenths (69.7%) of the Directors, a considerably larger percentage than answered either "a great deal" (6.1%) or "quite a bit" (9.1%).

2. Local Provider Responses

Local providers, like local level program respondents and other types of providers, were queried about target groups for receiving T/TA and the amount of T/TA each group requires. Table D58 presents the data.

Table D58. T/TA Requirements by Target Groups: Local Providers (n=24)

Target Group	Percent of Local Providers Specifying Amount of T/TA Required				
	More	Same	Less	Don't Know	Not Applicable
Administrator	45.8	29.2	4.2	16.7	4.2
Coordinators	54.2	25.0	4.2	12.5	4.2
Teachers	70.8	16.7	4.2	8.3	--
Aides	66.7	20.8	--	12.5	--
Support Staff	54.2	16.7	--	20.8	8.3
Parents	79.2	8.3	--	8.3	4.2
Other	12.5	--	--	8.3	79.2

NOTE: Compare this Table with Table D48 (National Providers) and Table D50 (Regional Providers).

Table D57. Amount of T/TA Reptition Required by Staff Turnover (DSP n=428)

REPTITN	REGION II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
20. A GREAT DEAL	0	1	3	3	0	1	0	8
	0.0	50.0	0.0	0.0	0.0	50.0	0.0	6.1
	0.0	16.7	0.0	0.0	0.0	33.3	0.0	
	0.0	3.0	0.0	0.0	0.0	3.0	0.0	
21. QUITL A BIT	1	0	1	0	1	0	0	3
	33.3	0.0	33.3	0.0	33.3	0.0	0.0	9.1
	16.7	0.0	20.0	0.0	50.0	0.0	0.0	
	3.0	0.0	3.0	0.0	3.0	0.0	0.0	
22. SOME	0	3	2	3	0	2	3	13
	0.0	23.1	15.4	23.1	0.0	15.4	23.1	39.4
	0.0	50.0	40.0	50.0	0.0	66.7	60.0	
	0.0	9.1	6.1	9.1	0.0	6.1	9.1	
23. A LITTLE	5	2	0	2	0	0	1	10
	50.0	20.0	0.0	20.0	0.0	0.0	10.0	30.3
	83.3	33.3	0.0	33.3	0.0	0.0	20.0	
	15.2	6.1	0.0	6.1	0.0	0.0	3.0	
24. NONE	0	0	2	1	1	0	0	4
	0.0	0.0	50.0	25.0	25.0	0.0	0.0	12.1
	0.0	0.0	40.0	16.7	50.0	0.0	0.0	
	0.0	0.0	6.1	3.0	3.0	0.0	0.0	
99. NOT APPL	0	0	0	0	0	0	1	1
	0.0	0.0	0.0	0.0	0.0	0.0	100.0	3.0
	0.0	0.0	0.0	0.0	0.0	0.0	20.0	
	0.0	0.0	0.0	0.0	0.0	0.0	3.0	
COLUMN TOTAL	6	6	5	6	2	3	5	33
	18.2	18.2	15.2	18.2	6.1	9.1	15.2	100.0

There is considerable range of percentages of local providers indicating more T/TA is required among the various groups. Most local providers said parents need more (79.2%). This figure is high as it was for regional (88.3%) and national (70.6%) (see Tables D48 and D50) providers. Most repondents among all three types of providers felt parents were the group most in need of more T/TA. And, as for the other providers, this finding correlates with the fact that parent involvement T/TA is among the top three categories of T/TA most frequently offered by local providers (see Table D32).

After parents, the groups most frequently mentioned by local providers as needing more T/TA were teachers (70.8%) and aides (66.7%). Administrators, coordinators, and support staff was seen as needing more T/TA by only about half the local providers. The percentages for each of these last three categories of people are lower from local providers than from either regional or national providers. However, both regional and local providers share the feeling that administrators and coordinators least need more T/TA. National providers differ by indicating that these two groups, along with parents, are most in need of more T/TA.

Trying to pull these findings together to see patterns is difficult and the generalizations take on a tentative quality. But, while most providers at each level agreed that parents, of all groups, required more T/TA, national providers distinguished the least among all the groups mentioned. They seem to see the need for more T/TA to all groups as relatively high and more universal, so the variances in responses among the groups are small. Regional providers make more distinctions among these groups, and focus more on the volunteer groups (aides and parents) than the administrative/coordinative groups. Local providers reveal a similar pattern, but the dichotomy is intensified. They seem to stress not only the volunteer groups but also the teachers, what might

be called the whole educative sector (both structured and nonstructured), more than the administrative sector.

Regional variations among local providers did emerge on these items and are detailed below:

- For administrators, the "norm" for local providers who wanted more T/TA was 45.8%. Regions III (Philadelphia) and V (Chicago) providers were higher (each 66.7%), and Regions IV (Atlanta) and XI (IMPD) providers, lower (22.2% and 33.3% respectively). The "norm" for same amount of T/TA was 29.2%; Region IV was higher (44.4%), as was Region XI (66.7%), while no Region V providers (0.0%) answered same. Three, however, (33.3%) said don't know.

- For coordinators, the "norm" for local providers wanting more T/TA was 54.2%. Regions III and V providers were higher (each 66.7%), while Region XI providers were lower (33.3%). Compared to the "norm" wanting same amount of T/TA (25.0%), Region V was low (11.1%) and Region XI high (66.7%).

- For teachers, the "norm" for local providers who felt more more T/TA is required was 70.0%. No significant regional variations occurred. But for same amount of T/TA, the "norm" was 16.7%, and Region III providers were low (0.0%), while Region XI providers were high (33.3%).

- For aides, the "norm" among local providers wanting more T/TA was 66.7%. Region III providers were unanimous on this amount required (100.0%). For same amount of T/TA, Regions IV and XI were higher than the "norm," each 33.3% compared to 20.8%.

- For support staff, the "norm" for wanting more T/TA was 54.2%. Regions III and IV were higher (each 66.7%), and Region XI lower, 33.3%. For same amount of T/TA, the "norm" was 16.7%; Regions III and IV were lower (0.0% and 11.1% respectively, while Region XI was higher (33.3%).

- For parents, the "norm" for providers indicating more T/TA is required was 79.2%. Regions III and XI providers fell somewhat lower, each 66.7%. The "norm" for same amount of T/TA was 8.3%, and only Region XI varied marketly with 33.3%.

Summation of D4 Findings: Distribution of T/TA Among Target Groups

The question addressed in this section was, "How equitably is T/TA distributed to the various Head Start target or consumer groups?"

National office staff saw the distribution of T/TA as follows (Table D47):

Professional Staff	35.3%
Paraprofessional Staff	33.9%
Support Staff	10.0%
Parents	21.0%

Comparing professionals with non-professionals (thus grouping paraprofessionals, support staff, and parents together), central office staff perceived the following breakdown:

Professional Staff	35.3%
Non-professionals	64.7%

Of the group of 24 central office staff interviewed, 18 could not identify whether or not delivered T/TA service was based upon needs assessment data derived from actual needs assessment processes; the other 6 respondents, however, all answered in the affirmative.

For the national provider group seven target groups were identified: Administrators, Coordinators, Teachers, Aides, Support Staff, Parents, Other. The provider group was then asked if each group should receive more, less, or the same amount of T/TA. Responses indicated a clear feeling that more T/TA ought to be provided for all groups; no response stated that any group should receive less. Parents and coordinators, closely followed by administrators, were the most frequently named as in need of more T/TA (Table D48).

Regional office staff perceived the percentage of T/TA delivered to target groups as follows (Table D49):

Professionals	38.4%
Paraprofessionals	29.3%
Support Staff	9.3%
Parents	23.9%

Note the similarity with national office perceptions. Grouping the professional and non-professional personnel receiving T/TA, the figures are:

Professional Staff	38.4%
Non-professional Staff	61.6%

When asked whether the delivered T/TA was based upon actual needs assessment data 15 regional staff replied affirmatively and 10 answered negatively.

Regional office staff also identified each of the four target groups given above as having "high" or "medium" need for T/TA service; no one perceived the need to be "low".

As was the case with national providers, the regional provider group was also asked whether the seven identified target groups (Administrators, Coordinators, Teachers, Aides, Support Staff, Parents, Other) needed more, less, or the same amount of T/TA. For each category, again the majority of respondents identified all categories (target groups) as needing more T/TA; a very small percentage stated that Administrators, Coordinators, and Support Staff needed less (Table D50).

Likewise, local program directors, staff, and parents were asked if the above seven target groups needed more, less, or the same amount of T/TA. Once again the overwhelming majority of respondents perceived the need for more T/TA for all concerned groups (Table D51).

Finally, local providers were asked which groups need more, less or the same amount of T/TA. As with the other respondent groups, local providers saw an overwhelming need for more T/TA for all groups (Table D58).

In this section a detailed discussion of the impact that staff turnover has on T/TA planning for the subsequent year was presented. When directors were asked about this issue, some 84.9% responded that there was a need for "a little," "some," "quite a bit," or "a great deal" of T/TA needed due to the turnover factor.

As in other topic areas addressed in this study, there were notable differences between various regions on this question of the equitable and needed distribution of T/TA resources.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

SECTION D5. How effectively are T/TA content areas being covered?

Still another key indicator of T/TA delivery in Project Head Start is what types and how well content categories are provided. For example, if improved administration of programs is a goal, is T/TA being made available accordingly? Data have already been displayed and discussed in Section D2 on categories of T/TA most frequently offered by providers (see Table D8, National Providers; Table D17, Regional providers, and Table D32, Local Providers; also Table D35, a comparison of all three kinds of providers). What will be focused on this section, as opposed to areas of content covered, are T/TA content areas being either totally overlooked or inadequately covered.

In this section the topic will be addressed at the national, regional, and local levels.

a. National Level (Providers) Responses

No data on this topic was collected from OCD Headquarters officials. However, a number of questions relating to the topic were put to those providers interviewed.

First, the 34 national providers interviewed asked: "Are there any specific content areas that are totally overlooked by your organization and which should be addressed?" Their responses were:

Table D59. T/TA Content Areas Totally Overlooked by National Providers (n=34)

Responses	Percent
Yes	20.6
No	67.6
Don't Know	5.9
Not Applicable	5.9

Those respondents who said 'no' were a majority. With the one-fifth who said yes, we requested that they specify those areas being overlooked. Table D60 presents the categories and percent response.

Table D60. Categories of T/TA Totally Overlooked by National Providers (n=6/34)

Categories of T/TA Totally Overlooked	Percent*
Special staff needs	--
Child development/psychology training	2.9
Nutrition training	--
Handicapped training	2.9
Health training	--
Administration/management	2.9
Parent involvement/education	--
Career development	--
Staff and program evaluation	--
Interpersonal relations	5.9
Bilingual/bicultural	2.9
Other	8.8

*The percent is calculated on the entire n of 34 national providers, even though only six of them answered this question. Multiple responses were allowed.

The frequencies shown for each category are very small. A couple of categories require explanation. Interpersonal relationships (5.9%) referred to those among staff, or between parents and children, or between parents and staff. "Other" (8.8%) included social services resource training or the need to share resources for local program personnels' skills improvement at a national level.

From the questions about T/TA content areas being totally overlooked, we went on with national providers to determine if any categories of T/TA were being inadequately covered. On this question the percent of providers responding "Yes" rose dramatically compared to the question on T/TA totally overlooked. Over half said areas of T/TA were being inadequately covered by their provider organization.

When we asked these providers to specify the types of T/TA inadequately covered, their responses blanketed a variety of topics (Table D62). Most frequently mentioned (with the exception of "other") was lack of in-depth T/TA (14.7%). These responses link with some mentioned

Table D61. T/TA Content Areas Inadequately Covered by National Providers (n=34).

Responses	Percent
Yes	52.9
No	35.3
Don't Know	2.9
Not Applicable	8.8

under "other," in which the providers indicated that 30 days was too short a time to cover what was needed and that the timing of consultant

Table D62. Categories of T/TA Inadequately Covered by National Providers (n=18/34)

Categories of T/TA Inadequately Covered	Percent*
Teacher training (skills; methodology)	--
Teacher aide/volunteer training (general)	--
Coordinator training (general and specific to component)	--
Parent involvement/education training (general and specific, e.g., 70.2 and parental skills)	--
Career development (general and specific, e.g., CDA)	--
Child development/psychology	2.9
Nutrition	2.9
Specific handicap training/recruitment	2.9
Health (mental, dental)	5.9
Social services mobilization/community involvement	2.9
Administration/management	8.8
Performance standards	8.8
Bilingual/bicultural	--
Interpersonal relations	--
In-depth T/TA	14.7
Other	17.6

*The percent is calculated on the entire n of 34, even though only 18 of them answered this question. Multiple responses were allowed.

availability to the regional office was such that appropriate input could not be made. (Other responses under "other" included "limitations of staff and resources" and "see final report", not a particularly helpful answer.) Next most frequently mentioned was administrative/management

T/TA and performance standards T/TA (each 8.8%). Health T/TA was mentioned by 5.9% of the respondents, and the other categories fell to a 2.9% level.

b. Regional Level Responses

Regional level responses on this topic of T/TA content categories and all other succeeding topics in this chapter are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1. Regional Office Responses

These responses are further divided into two parts: an integrated analysis of responses from all 11 regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter.

a) Aggregated analysis of all 11 regions

(See Chapter II for an explanation of the selection process for interviewees in the Regional Offices.)

Inquiry was made of the 64 RO staff interviewed as to content areas which had received little or no attention and in which need was perceived for significantly greater T/TA efforts. The primary area in which the greatest need was perceived was that of "Management Skill" including "Fiscal Management."

Other areas, each of which were noted once, are:

- Group dynamics
- Parental involvement

- Child development
- Headquarters Objectives and Philosophy
- Social services
- Handicapped Mandate

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study." Regional Office on the topic of T/TA content categories. (See Chapter II for an explanation about the selection of the "case studies.")

NEW YORK (II)

Region II staff perceive fewer unmet T/TA needs than most other regions. The reason most frequently cited for this phenomena is the fact that Region II has a full-time contractor in the major areas of Management and Parent Involvement which are frequently cited as needs by other regions.

PHILADELPHIA (III)

Several areas of need were thought to be overlooked by T/TA services provided in Region III. The areas of management skills (which was also described as "diplomacy"), group dynamics, parenting, and child development were all seen as areas of need that were being overlooked.

ATLANTA (IV)

When asked about the possibility of certain need areas which have not been addressed, some Regional Office staff perceived the need for

T/TA to upper level personnel in management skill and techniques. Presumably, this T/TA--particularly in the area of MBO--would aid in the development of a management system leading to clear statements of managerial expectations/objectives and measurement/accountability methodology.

CHICAGO (V)

Very little data was given in Region V in answer to the question as to what areas of need, if any, were being overlooked. Only management skills was mentioned by one respondent.

DALLAS (VI)

The only area of need that was thought to be overlooked by T/TA providers in Region VI was that of planning, but it should be noted that four out of six were not asked this question.

SEATTLE (X)

Most respondents in Region X feel there are no real areas of need being overlooked, but that many areas, such as handicapped training, need more attention. One respondent felt that policy committee people, mostly parents, need more training as to their role in Head Start.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

Scant data is available from IMPD as to areas of need that were overlooked by T/TA providers, but management skills and fiscal management were both mentioned as being overlooked by those who did respond.

2. Regional Provider Responses

These resources are also further divided into two parts: group one, 42 respondents from the (generally) most experienced RTO/STO/STATO/OICS network staff across the country, and group two, 77 respondents from a variety of providers: HSST/CDA, LDP, RTO/STO/STATO/OICS, and state, multi-state, or region-wide organization, all of whom were chosen because they serve the local programs selected in our sample for on-site interviews. This format for presenting regional provider responses will be followed throughout this chapter on findings.

a) Group One: RTO/STO/STATO/OICS network responses (aggregated across all 11 regions)

Presented in this section is an analysis of the responses received from RTO/STO network personnel on the subject of T/TA content categories. (See Chapter II for a detailed explanation on the selection process for these individuals.)

When asked if T/TA was inadequate in any areas, 73% of 41 respondents answered "Yes." There were differences in opinion on this issue in several regions, however, Regions VII, VIII, and IX were unanimous in responding "Yes" to this question. Interestingly, aide training was never indicated as an area of inadequacy. Fiscal management was only indicated three times (twice in Region IX and once in Region VII) and management skill only six times (twice in Regions VII and VIII and once in Regions V and VI). "Other" areas of inadequacy were indicated 23 times, which appears unusual for this survey, in which "other" categories did not generally attract much attention.

A variety of subject areas were cited as being inadequate, and only three subjects, "social services," "parent education," and "Health" were mentioned by more than one person. The subject areas mentioned were:

- Social Services
- Interpersonal Management Skills
- Political Education
- A-102 Procedures
- Parent Education on Child Abuse
- Parent Education
- Policy Setting
- PI&S Services
- Personnel Evaluation
- Child Development
- Health and Handicaps
- Health
- Monitoring T/TA
- Parent Involvement
- Career Development

b) Group Two: Various Regional Provider Responses (aggregate across seven case study regions only)

Presented in this section is an analysis of the responses received from the 77 regional providers on the subject of T/TA content categories. (See Chapter II for an explanation of the selection process for these individuals.) Regional variations in these data will be highlighted as appropriate.

In an effort to unearth content areas of T/TA which should be attended to, we asked regional providers "Are there any specific content areas of T/TA that are totally overlooked by your organization and which should be addressed?" Nearly three-fourths of these

Table D63. T/TA Content Areas Totally Overlooked by Regional Providers (n=77)

Responses	Percent
Yes	18.2
No	72.7
Don't Know	3.9
Not Applicable	5.2

NOTE: Compare this Table with Table D59 on National Providers.

providers said no. This level of response was on a par with national providers (67.6%). With those regional providers who said yes, a

request to specify the content areas being overlooked was made. The specifics are displayed here in Table D64.

Table D64. Categories of T/TA Totally Overlooked by Regional Provider (n=14/77)

Categories of T/TA Totally Overlooked	Percent*
Special staff needs (pre-service training; specific component)	2.6
Child development/psychology training	--
Nutrition training	2.6
Handicapped training (identification and management)	--
Health training	3.9
Administration/management	1.3
Parent involvement/education	1.3
Career development	2.6
Staff and program evaluation	1.3
Interpersonal relations	--
Bilingual/bicultural	--
Other	3.9

*The percent is calculated on the entire n of 77 regional providers, even though only 14 of them answered this question. Multiple responses were allowed.

NOTE: Compare this Table with Table D60 on National Providers.

Like national providers, the responses varied, and with the exception of administrative training, there is no duplication of categories mentioned between the two groups of providers. The total number of respondents here is very small. Health and "other" (which includes "clerical staff training" and "more people to provide T/TA")

were each mentioned by 3.9% of the sample. The remaining categories have even lower percentages.

No particular regional variations occur here because the number indicating areas of T/TA are totally overlooked is so small. Two regions (II-New York and VI-Dallas) were not represented at all in this specification because all their providers said no areas were totally overlooked.

Next regional providers were asked if any content areas of T/TA were being inadequately covered. A majority said "Yes," just as did national providers, although their percent was lower (52.9%). Regional variations did occur on this variable. The "norm" is

Table D65. T/TA Areas Inadequately Covered by Regional Providers (n=77)

Responses	Percent
Yes	64.9
No	29.9
Don't Know	1.3
Not Applicable	3.9

NOTE: Compare this Table with Table D61 on National Providers.

64.9%. The regions' providers who were higher than the "norm" were II New York (100.0%), X Seattle (77.8%), and XI IMPD (80.0%). Regions whose providers were lower than the "norm" were III Philadelphia (42.9%) and V Chicago (50.0%).

When requested to specify the content areas inadequately covered, regional providers obliged with a gamut of categories.

Table D66. Categories of T/TA Inadequately Covered by Regional Providers (n=52/77)

Categories of T/TA Inadequately Covered	Percent*
Teacher training (skills; methodology)	3.9
Teacher aide/volunteer training (general)	5.2
Coordinator training (general and specific to component)	5.2
Parent involvement/education training (general and specific, e.g., 70.2 and parental skills)	15.6
Career development (general and specific, e.g., CDA)	7.8
Child development/psychology	1.3
Nutrition (general and specific, e.g., cook)	7.8
Specific handicap training/recruitment	10.4
Health (mental, dental, medical, safety)	9.1
Social services mobilization/community involvement	9.1
Administration/management (including fiscal and PAC)	19.5
Performance standards/I&I/certification	7.8
Bilingual/bicultural	1.3
Interpersonal relations	1.3
In-depth T/TA	3.9
Other (includes transportation/maintenance, expressive arts, more training by tribe, etc.)	5.2

*The percent is calculated on the entire n of 77, even though only 52 of them answered the question.

NOTE: Compare this Table with Table D62 on National Providers.

Of all categories, administration/management T/TA was mentioned by most providers (19.2%). Next most frequently mentioned was parent involvement/education (15.6%). The majority of these responses referred to parent involvement T/TA. This category was followed by specific handicap training/recruitment (10.4%). The other categories fell below the 10.0% mark.

Only a few regional variations appeared among these categories. Remember that we are looking at the proportion of each region's provider who vary from the "norm" by a 10.0% or more differential.

- Region II (New York) providers were higher than the "norm" for the following categories: career development (25.0% vs. the "norm" of 7.8%); specific handicap training/recruitment (25.0% vs. 10.4%); performance standards/I&I/certification T/TA (25.0% vs. 7.8%); and in-depth T/TA (25.0% vs. 3.9%).

- Region X (Seattle) providers were higher (33.3%) than "norm" (15.6%) for parent involvement/education T/TA.

- Region XI (IMPD) providers were higher than the "norm" for these categories of T/TA: coordinator training (20.0% vs. the "norm" of 5.2%); specific handicap training/recruitment (30.0% vs. 10.4%); and health (20.0% vs. 9.1%).

c. Local Level Responses

Local level responses on this topic of content areas of T/TA, and all other topics in this chapter on findings, are discussed first from the viewpoint of Directors, staff, parents, and (where appropriate) community leaders associated with the 30 Head Start programs sampled and then from that of local level T/TA providers

1. Local Program Responses

Project staff interviewed a total of 428 directors, staff, and parents. (See Chapter II for an explanation of the selection process.) By way of ascertaining what needed T/TA might not be forthcoming at the local program level, KAI Field Research Associates asked all 428 respondents in this category if there were any specific content areas of T/TA (e.g., fiscal management) that have been totally overlooked by the various providers from whom they receive services. Their answers are displayed here in Table D67, following this page.

More than four out of every ten respondents (43.0%) felt that no content areas were being overlooked. Only one out of five (19.9%) felt there were some being overlooked. In other words, of the 62.9% who answered yes or no to this item (the other 37.1% all said either "don't know" or "not applicable"), one-third said areas of T/TA were being overlooked and two-thirds said they were not.

Among Region VI Dallas respondents, a different perspective on things emerged--of the 67.3% in that region who answered either yes or no to the question, 59.6% said no T/TA areas were being overlooked and only 7.7% thought some were. This suggests that interviewees in this particular region, more than in any other case study, do not think certain areas of T/TA are being overlooked.

The same question was also put to the 162 community leaders interviewed in the seven case study regions. Their responses are shown here in Table D68, following Table D67.

More than half the respondents (5.1%) felt that no content areas were being overlooked. One-fourth (23.8%) approximately said there were some.

Table D67. T/TA Content Areas Totally Overlooked (DSP n=428)

OVERLOOK	COUNT / ROW PCT / COL PCT / TOT PCT	REGION 1	REGION III	REGION IV	REGION V	REGION VI	REGION X	REGION XI	ROW TOTAL
		2.1	3.1	4.1	5.1	6.1	10.1	11.1	
1. YES	COUNT	14	12	12	13	4	12	11	89
	ROW PCT	15.7	13.5	13.5	14.6	4.5	13.5	24.7	20.8
	COL PCT	29.2	17.1	16.9	23.6	9.1	25.5	26.2	
	TOT PCT	3.3	2.8	2.8	3.0	0.9	2.8	2.6	
2. NO	COUNT	18	39	33	29	41	19	15	194
	ROW PCT	9.3	20.1	17.0	14.9	21.1	9.8	7.7	45.3
	COL PCT	37.5	55.7	46.5	52.7	83.7	40.4	35.7	
	TOT PCT	4.2	9.1	7.7	6.8	9.6	4.4	3.5	
8. DON'T KNOW	COUNT	11	22	25	13	4	16	14	144
	ROW PCT	7.6	15.3	17.4	9.0	2.8	11.1	9.7	33.6
	COL PCT	22.9	31.4	35.2	23.6	8.2	34.0	33.3	
	TOT PCT	2.6	5.1	5.1	3.0	0.9	3.7	3.3	
9. NOT APPL	COUNT	5	3	1	0	0	0	1	10
	ROW PCT	33.3	20.0	6.7	0.0	0.0	0.0	6.7	2.3
	COL PCT	10.4	4.3	1.4	0.0	0.0	0.0	2.4	
	TOT PCT	1.2	0.7	0.2	0.0	0.0	0.0	0.2	
COLUMN TOTAL		48	70	71	55	49	47	42	428
		11.2	16.4	16.6	12.9	11.4	11.0	9.8	100.0

Table D68. T/TA Content Areas Totally Overlooked (CL n=162)

TRGAOLKD		RGN II	RGN III	RGN IV	RGN V	RGN VI	RGN X	RGN XI	ROW TOTAL
		2.0	3.0	4.0	5.0	6.0	10.0	11.0	
YES	1.	5	6	1	8	3	5	8	36
		13.9	16.7	2.8	22.2	8.3	13.9	22.2	23.8
		31.3	23.1	3.7	29.6	15.8	25.0	47.1	
		3.3	4.0	0.7	5.3	2.0	3.3	5.3	
NO	2.	5	14	16	12	12	13	5	77
		6.5	18.2	20.8	15.6	15.6	16.9	6.5	51.0
		33.3	53.8	59.3	44.4	63.2	65.0	29.4	
		3.3	9.3	10.6	7.9	7.9	8.6	3.3	
DON'T KNOW	3.	5	5	10	7	3	1	4	35
		14.3	14.3	28.6	20.0	8.6	2.9	11.4	23.2
		33.3	19.2	37.0	25.9	15.8	5.0	23.5	
		3.3	3.3	6.6	4.6	2.0	0.7	2.6	
N-A	4.	0	1	0	0	1	1	0	3
		0.0	33.3	0.0	0.0	33.3	33.3	0.0	2.0
		0.0	3.8	0.0	0.0	5.3	5.0	0.0	
		0.0	0.7	0.0	0.0	0.7	0.7	0.0	
COLUMN TOTAL		16	26	27	27	19	20	17	151
		9.9	17.2	17.9	17.9	12.6	13.2	11.3	100.0

Region X Seattle and VI Dallas respondents gave "no" (i.e., no T/TA areas are being overlooked) as a response more often than in any other region or than the "norm" of 51.0%. Their "no" frequencies of response were 65% and 63.2% respectively. In other words, more community leaders interviewed in those two case-studies tend to believe T/TA areas are not being overlooked than similar respondents in the other five regions.

Region VI Dallas stands out then as the only case study wherein its directors, staff, parents, and community leaders allied their counterparts in the other six regions studies regarding their belief that T/TA areas of content were not being overlooked.

Next all local respondents were requested to specify the content areas they thought were being overlooked. They were given the chance to list up to three areas of T/TA which they thought were being totally overlooked. The results of their answers have been tabulated by frequency of response and are displayed here in Table D69.

Table D69. Categories of T/TA Totally Overlooked: Directors, Staff, Parents, and Community Leaders (n=590)

Categories of T/TA Totally Overlooked	Percent*
Special staff needs (pre-service training; specific component)	1.2
Child development/psychology training	2.8
Nutrition training	0.8
Handicapped training (identification and management)	2.5
Health training (mental, dental, medical, safety)	1.3
Administration/management (includes fiscal, PAC)	7.1
Parent involvement/education	2.8
Career development	0.3
Objective evaluation of staff and program	0.6
Interpersonal relations	3.5
Bilingual/bicultural	1.2
Other	5.4

*Percent is calculated on the entire n of 590.

Several items were mentioned more frequently than others:

administration/management	7.1% frequency
interpersonal relations	3.5% frequency
parent involvement/education	2.8% frequency
child development/psychology training	2.8% frequency

These figures might serve as a barometer of sorts indicating topic areas most often mentioned. However, even the most frequently-mentioned T/TA area--administration/management--was mentioned by only 7.1% of the total number of interviewees (590). As a result it is difficult to draw very strong conclusions from these particular data.

Then, by way of further ascertaining what needed T/TA might not be forthcoming at the local program level, KAI/FRA's asked all those directors, staff, and parents interviewed if they thought any specific content areas of T/TA were not being adequately covered by the various providers from whom they receive services. Their answers are displayed here in Table D70, following this page.

Roughly, one-third of the respondents (34.3%) reported that they did not think any areas of T/TA were being inadequately covered. Almost as many, however, 29.9%, in fact, said, to the contrary, there were areas not being covered adequately. The other third (approximate) of respondents (35.7%) said either they did not know or the question was not applicable.

As would be predicted, more respondents (29.9%) said some T/TA areas were being inadequately covered than those (19.9%) who reported areas being totally overlooked.

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Table D70. T/TA Content Areas Inadequately Covered (DSP n=428)

INADQTE		REGION 2.1	3.1	4.1	5.1	6.1	10.1	11.1	ROW TOTAL
	1.	16	20	14	15	11	14	32	128
YES		12.5	20.3	10.9	11.7	8.6	10.9	25.0	29.9
		33.3	33.3	19.7	23.8	21.2	25.5	52.5	
		3.7	6.1	3.3	3.5	2.6	3.3	7.5	
	2.	17	26	27	25	27	18	7	147
NO		11.6	17.7	18.4	17.0	18.4	12.2	4.8	34.3
		35.4	33.3	38.0	39.7	51.9	32.7	11.5	
		4.0	6.1	6.5	5.8	6.3	4.2	1.6	
	8.	10	22	29	21	14	22	22	140
DON'T KNOW		7.1	15.7	20.7	15.0	10.0	15.7	15.7	32.7
		20.8	28.2	40.8	33.3	26.9	40.0	36.1	
		2.3	5.1	6.8	4.9	3.3	5.1	5.1	
	9.	5	4	1	2	0	1	0	13
NOT APPL		38.5	30.8	7.7	15.4	0.0	7.7	0.0	3.0
		10.4	5.1	1.4	3.2	0.0	1.8	0.0	
		1.2	0.0	0.2	0.5	0.0	0.2	0.0	
COLUMN TOTAL		48	78	71	63	52	55	61	428
		11.2	18.2	16.6	14.7	12.1	12.9	14.3	100.0

Region VI Dallas respondents answered "no, no areas were being inadequately covered" more frequently (51.9% of the time) than either the "norm" of 34.3% or any other individual region. This finding, coupled with the previous one where their interviewees led those of all other regions in answering "no" to the question about whether any T/TA areas are being totally overlooked, suggests that apparently the persons interviewed in that region generally think their T/TA is more comprehensive than do respondents in any of the other regions.

This same question on T/TA areas being inadequately covered was also put to the 162 community leaders interviewed. Their responses are displayed here in Table D71, following this page.

Forty percent (40.4%) of the community leaders reported that they did not think any areas of T/TA were being inadequately covered. Nearly as many, however, 34.4%, said, to the contrary, that there were areas not being covered adequately.

More community leaders reported some T/TA areas were being inadequately covered (34.4%) than those being totally overlooked (23.8%). This pattern parallels that in the responses of the directors, staff, and parents and is not surprising in itself.

Two regions' respondents answered "no, no T/TA areas being inadequately covered" more frequently than the others or the "norm" of 40.4%--Region IV Atlanta (48.1% of the time) and Region XI IMPD (47.1%).

Table D71. T/TA Content Areas Inadequately Covered (CL n=162)

INADTGAS	RGN	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	COUNT								
	ROW PCT								
	COL PCT								
	TOT PCT	2.	3.	4.	5.	6.	10.	11.	
YES	1.	5	8	8	9	8	8	6	52
		9.6	15.4	15.4	17.3	15.4	15.4	11.5	34.4
		33.3	30.8	29.6	33.3	42.1	40.0	35.3	
		3.3	5.3	5.3	6.0	5.3	5.3	4.0	
NO	2.	6	11	13	8	7	8	8	61
		9.8	18.0	21.3	13.1	11.5	13.1	13.1	40.4
		40.0	42.3	48.1	29.6	36.8	40.0	47.1	
		4.0	7.3	8.0	5.3	4.6	5.3	5.3	
DON'T KNOW	3.	4	6	6	10	4	3	3	36
		11.1	16.7	16.7	27.8	11.1	8.3	8.3	23.8
		26.7	23.1	22.2	37.0	21.1	15.0	17.6	
		2.6	4.0	4.0	6.6	2.6	2.0	2.0	
N-A	4.	0	1	0	0	0	1	0	2
		0.0	50.0	0.0	0.0	0.0	50.0	0.0	1.3
		0.0	3.8	0.0	0.0	0.0	5.0	0.0	
		0.0	0.7	0.0	0.0	0.0	0.7	0.0	
COLUMN TOTAL		15	26	27	27	19	20	17	151
		9.9	17.2	17.9	17.9	12.6	13.2	11.3	100.0

NOTE: Compare this Table with Table D70 which shows the responses of the directors, staff, and parents.

Next all these respondents (directors, staff, parents, and leaders) were requested to specify the content areas they thought were not being adequately covered. They were afforded the opportunity to list up to three areas of T/TA which they believed were being inadequately covered. The results of their answers have been tabulated by frequency of response and are displayed here in Table D72.

Table D72: Categories of T/TA Inadequately Covered: Directors, Staff, Parents, and Community Leaders (n=590)

Categories of T/TA Inadequately Covered	Percent*
Teacher training (skills; methodology)	6.1
Teacher aide/volunteer training (general)	1.6
Coordinator training (general and specific to component)	5.4
Parent involvement/education training (general and specific, e.g., 70.2 and parental skills)	16.6
Career development (general and specific, e.g., CDA)	2.2
Child development/psychology	3.0
Nutrition (general and specific, e.g., cooks)	6.7
Specific handicap training/recruitment	12.0
Health (mental, dental, medical, safety)	2.8
Social services mobilization/community involvement	4.5
Administration/management (including fiscal and PAC)	13.3
Performance standards/I&I/certification	1.1
Bilingual/bicultural	5.4
Interpersonal relations	3.8
In-depth T/TA	3.7
Other (includes transportation/maintenance, expressive arts, more training by tribe, etc.)	11.1

*The percent is calculated on the entire n of 590, even though not all of them responded obviously. Multiple responses were allowed.

Again, several items were mentioned more frequently than others:

Parent involvement/education training	16.6% frequency
Administration/management	13.3% frequency
Special handicapped training/recruitment	12.0% frequency
Other (e.g., transportation, maintenance, expressive arts, etc.)	11.1% frequency

These figures might well serve as a barometer of sorts pointing to the topic areas most frequency mentioned. These are also useful compared to the findings from the earlier query on specific areas being totally overlooked (see Table B69). Such a comparison across tables shows that two content areas were among the top four or five on both questions, in terms of total or combined frequency of response:

Parent involvement/education	12.4% frequency
Administration/management	20.4% frequency

It would, therefore, seem that these two content areas of T/TA are ones on which there is most agreement by respondents in this study that additional attention is warranted.

Another form of analysis was done on these data on T/TA areas overlooked and inadequately covered--the cross tabulation of each with the ratings on satisfaction (see Table E9) and extent of impact of T/TA

(Table E34). These cross tabulations are displayed here in Tables D73 and D74 along with appropriate narration.

Table D73. Cross Tabulation of T/TA Areas Overlooked and Inadequately Covered With Satisfaction Level of T/TA Provided to Local Program (DSP)

T/TA Areas Overlooked or Inadequately Covered	Percent Indicating Level of T/TA Satisfaction and T/TA Areas Overlooked or Inadequately Covered.			Total Percent Indicating T/TA Areas Overlooked or Inadequately Covered
	Very Satisfied	Satisfied	Dissatisfied/ Very Dissatisfied	
T/TA Areas Overlooked				(n=284)
Yes	25.9	46.9	27.2	30.7
No	38.8	50.8	10.4	69.3
T/TA Areas Inadequately				(n=270)
Yes	21.0	54.0	25.0	45.9
No	45.9	47.3	6.8	54.1

NOTE: The percents listed in the righthand column are based on varying numbers of respondents, as indicated. All "don't know" and "not applicable" responses have been omitted.

This table reveals that, among those answering "yes" to each of these questions, approximately three-quarters were very satisfied and satisfied and one-quarter dissatisfied and very dissatisfied. These percents are lower than for those answering "no" to each question, wherein approximately nine-tenths were very satisfied and one-tenth dissatisfied and very dissatisfied. (The dissatisfaction ratings decline somewhat for this group in regard to T/TA areas inadequately covered.)

Thus, if T/TA areas were perceived to be overlooked or inadequately covered, the percentage of respondents dissatisfied or very dissatisfied was higher than among those who did not perceive T/TA content areas to be improperly addressed.

Table D74. Cross Tabulation of T/TA Areas Overlooked and Inadequately Covered With Extent of Impact From T/TA Provided to Local Program (DSP)

T/TA Areas Overlooked or Inadequately Covered	Percent Indicating Extent of T/TA Impact and T/TA Areas Overlooked or Inadequately Covered				Total Percent Indicating T/TA Areas Overlooked or Inadequately Covered
	A Great Deal	Quite a Bit	Some	A Little/ None	
T/TA Areas Overlooked					(n=262)
Yes	28.4	27.2	24.7	19.8	30.9
No	35.4	34.3	26.5	13.9	69.1
T/TA Areas Inadequately					(n=270)
Yes	21.0	29.8	33.1	16.2	45.9
No	42.5	34.9	19.2	3.4	54.1

NOTE: The percents listed in the righthand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

A cross of T/TA content areas overlooked or inadequately covered with extent of T/TA impact shows that there is a relationship between T/TA content areas perceived as overlooked or inadequately covered and reduced impact of T/TA on the program. For T/TA areas overlooked, those rating impact at the high end of the scale (a great deal and quite a bit) totaled 55.6%, while those at the low end (some, a little/none) comprised

44.5%. The figures for T/TA inadequately covered were 50.8% and 49.2%, respectively. So roughly, the split between those rating impact high and those low is 50-50 on both items.

Among those saying no to both items, 69.7% gave high impact ratings on T/TA overlooked, and 30.4% low ratings, while for T/TA inadequately covered, the percentages were 77.4% and 22.6%, respectively. So the split between high and low impact ratings across both these items is approximately 70-30.

Summarizing these two items crossed with overall T/TA satisfaction and impact, the following statements are appropriate:

- A majority of respondents indicated positive satisfaction levels (very satisfied and satisfied) on both T/TA overlooked and inadequately covered categories, whether the answer was "yes" (72.8% and 75.3% respectively) or "no" (89.6% and 93.2% respectively). A majority also indicated high T/TA impact ratings (a great deal and quite a bit) for both categories of T/TA overlooked and inadequately covered ("yes," 55.6% and 50.8%, respectively and "no," 69.7% and 77.4%, respectively).

- There exists a strong relationship between those answering "no" to each item and high levels of satisfaction and impact. The relationship between those answering "yes" to each item and high levels of satisfaction and impact is less strong, particularly as regards impact.

- T/TA areas inadequately covered reveals slightly greater percentages of high satisfaction and impact levels than does T/TA areas overlooked across respondents answering both "yes" and "no," with one exception. Those who answered "yes," T/TA areas were inadequately covered, were the smallest percent of those who gave high T/TA impact ratings (50.8%).

- For both T/TA overlooked and inadequately covered, high ratings for impact are expressed by a lower percentage of respondents than are positive satisfaction ratings,

indicating that high impact is more difficult to "guarantee" regardless of whether T/TA is overlooked or inadequately covered (although the percentage of high impact ratings increased somewhat for the latter).

2. Local Provider Responses

As with other providers, local providers were queried as to whether any specific content areas of T/TA were being totally overlooked by their organization. Of all these respondents, 12.5% said yes. Now the startling

Table D75. T/TA Areas Totally Overlooked by Local Providers (n=24)

Responses	Percent
Yes	12.5
No	54.2
Don't Know	25.0
Not Applicable	8.3

NOTE: Compare this Table with Table D59 (National Providers) and Table D63 (Regional Providers).

thing about these responses is that all came from Region V (Chicago) respondents. They represent one-third of this region's local providers sampled. When asked to specify the categories, their responses were parent involvement/education (4.2%), child development/psychology (4.2%), and interpersonal relations (4.2%). The percent of local providers answering yes was lower than regional (18.2%) and national (20.6%) providers.

Next all local providers were asked if any specific content areas were being inadequately covered by their organization. Their responses were:

Table D76: T/TA Areas Inadequately Covered by Local Providers (n=24)

Responses	Percent
Yes	50.0
No	29.2
Don't Know	12.5
Not Applicable	8.3

NOTE: Compare this Table with Table D61 (National Providers) and Table D65 (Regional Providers).

Half the providers said yes, and this percent is lower than for regional (64.9%) and national (52.9%) providers. Local providers from Regions III (Philadelphia) and XI (IMPD) were higher (66.7% each) than the "norm" of 50.0%.

The categories of T/TA inadequately covered by these provider organizations are detailed as follows:

Table D77. Categories of T/TA Inadequately Covered by Local Provider Organizations (n=24)

Categories of T/TA Inadequately Covered	Percent*
Teacher training (skills; methodology)	--
Teacher aide/volunteer training (general)	--
Coordinator training (general and specific to component)	--
Parent involvement/education training	4.2
Career development (general and specific, e.g., CDA)	--
Child development/psychology	--
Nutrition (general and specific, e.g., cooks)	--
Specific handicap training	4.2
Health (mental, dental, medical, safety)	25.0
Social services mobilization/community involvement	--
Administration/management	4.2
Performance standards	8.3
Bilingual/bicultural	--
Interpersonal relations	--
In-depth T/TA	8.3
Other (includes transportation/maintenance, expressive arts, more training by tribe, etc.)	4.2

*The percent is calculated on the entire n of 24, even though not all of them answered. Multiple responses were allowed.

NOTE: Compare this Table with Table D62 (National Providers) and Table D66 (Regional Providers).

Of the providers who said there were T/TA areas not adequately covered, half (25.0%) specified health T/TA. Next most frequently mentioned categories were performance standards and in-depth T/TA (each 8.3%). Other categories were mentioned by 4.2% of all respondents.

There is no consensus among local, regional, and national providers on categories of T/TA not adequately covered. Nor are there regional variations among local providers worth noting.

Summation of D5 Findings: T/TA Content Areas Overlooked

In previous sections detailed discussion was put forth on the content areas covered in T/TA activities. This section dealt with those areas which had not been addressed or which were inadequately covered. The topic again was discussed from the perspectives of national, regional, and local levels.

Of the group of 34 national providers some 20% stated that they felt some specific content areas were overlooked in the delivery of T/TA delivery (see Table D59). Neglected content areas specified were child development/psychology, training in handicapped children, management and administration, interpersonal interactions, and bilingual/bicultural aspects (Table D60).

When asked about content areas inadequately covered, some 52.9% of the respondents perceived this phenomenon (Table D61). Such content areas specified were in-depth T/TA, performance standards, administration/management, social services mobilization, health and dental, specific handicapped training, nutrition, and child development (Table D62).

Regional office staff perceived the need for significantly greater T/TA efforts in the area of management skill including fiscal management; other areas mentioned were group dynamics, parental involvement, child development, Headquarters objectives and philosophy, social services, and the handicapped mandate.

Inquiry of the regional provider network of the RTO/STO/STATO/OICS revealed that 73% of 41 respondents saw a wide variety of unmet or inadequately covered T/TA needs; three areas -- social services, parent education, and healt -- were mentioned by more than one respondent.

Of the 77 group two regional providers, some 18.2% perceived some areas which were totally overlooked (Table D63); content areas specified were special staff needs, nutrition, health, administration/management, parent involvement, career development, and staff and program evaluation (Table D64); many specific areas were cited -- those most often mentioned were administration/management, parent education, and training for the handicapped (Table D66).

Of the 428 local directors, staff members, and parents who were interviewed approximately 19.9% felt some content areas were being overlooked; the three areas most frequently mentioned were administration/management, interpersonal relations, and parent education. (Table D69) This same group was asked about T/TA areas inadequately covered. Some 29.9% reported inadequate coverage of some content areas. When asked the same question, some 34.4% of the community leader group reported some area(s) that were not being adequately covered.

The total group of 590 directors, staff, parents, and community leaders most often identified three T/TA content areas that were being inadequately covered:

Parent involvement/education
Administration/management
Special training for the handicapped

When the local provider group was asked about T/TA content areas that were totally overlooked only 12.5% responded positively; however, all of these were from one region and specified parent education, child development, and interpersonal relations. When asked if there were areas inadequately covered some 50% reported this phenomenon. Health was the area most frequently specified followed by performance standards, in-depth T/TA, parent involvement, and specific training for the handicapped effort.

As was true in most other sections of this study, considerable variation was noted between regions in response to study questions.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

Section D6: How effectively are special content areas, i.e., nutriton, psychological services, and handicapped needs, being addressed?

This section has been created in order to afford special consideration for three particular content areas of T/TA that were of concern during the conduct of this evaluation to the executives of the Office of Child Development in Washington, D.C., in as much as the National Office had funded providers in each of these content areas to give service to both the regional and local levels. These special content areas of nutrition, psychological services, and handicapped needs should provide still another perspective on the overall subject of how well T/TA is delivered to Project Head Start.

Data on this subject has been collected at the local level only, and from the directors, staff and parents who were interviewed as part of the 30 program sample.

C. Local Level (Program) Responses

First off, these interviewees were queried as to how much more nutrition T/TA they thought was required to meet the needs of their program. They could answer "a great deal, quite a bit, some, a little, or none." Their answers are given here in Table D78.

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Table D78.. Need for More Nutrition T/TA (DSP n-428)

COUNT / ROW PCT / COL PCT / TOT PCT	REGN II 2.1	REGN III 3.1	REGN IV 4.1	REGN V 5.1	REGN VI 6.1	REGN X 10.1	REGN XI 11.1	ROW TOTAL
QUITE A DEAL 20.	4	11	11	4	4	5	9.19	50
	6.9	19.0	19.0	6.9	6.9	8.6	32.8	13.6
	8.3	14.1	15.5	6.3	7.7	9.1	31.1	
	0.9	2.5	2.6	0.9	0.9	1.2	4.4	
21.	6	14	15	11	9	6	19	80
QUITE A BIT	7.5	17.5	18.8	13.8	11.3	7.5	23.8	18.7
	12.5	17.9	21.1	17.5	17.3	10.9	31.1	
	1.4	3.3	3.5	2.6	2.1	1.4	4.4	
22.	20	24	20	34	19	15	15	157
SOME	12.7	15.3	13.5	21.7	12.1	9.6	9.6	36.7
	41.7	34.8	52.6	54.0	36.5	27.3	24.6	
	4.7	5.6	4.9	7.9	4.4	3.7	3.5	
23.	10	12	3	4	7	6	1	43
A LITTLE	23.3	27.9	7.0	9.3	16.3	11.6	2.3	10.0
	20.8	15.4	7.9	6.3	13.5	9.1	1.6	
	2.3	2.8	0.7	0.9	1.6	1.2	0.2	
24.	4	7	3	6	7	1	1	48
NONE	8.3	14.6	6.3	12.5	14.6	2.1	2.1	11.2
	8.3	9.0	5.3	9.5	13.5	1.8	1.6	
	0.9	1.6	0.7	1.4	1.6	0.2	0.2	
88.	4	5	4	5	4	5	6	33
DON'T KNOW	12.1	15.2	12.1	15.2	12.1	15.2	18.2	7.7
	8.3	6.4	5.3	7.9	7.7	9.1	9.8	
	0.9	1.2	0.9	1.2	1.0	1.2	1.4	
99.	0	3	1	1	2	1	1	9
NOT APPL	0.0	33.3	11.1	11.1	22.2	11.1	11.1	2.1
	0.0	3.8	1.8	1.6	3.8	1.8	1.6	
	0.0	0.7	0.2	0.2	0.9	0.2	0.2	
COLUMN	48	78	57	63	52	55	61	428

Considering all responses across the seven case studies together, it is apparent that the distribution of answers could be portrayed in this fashion:

One third: high need for more nutrition T/TA

32.3% — 13.6% a great deal; 18.7% quite a bit

One third: some need for more nutrition T/TA

36.7% - some

One fifth: a little or no need for more nutrition T/TA

21.2% — 10.0% a little; 11.2% none

One tenth: don't know or not applicable

9.8% — 7.7% don't know; 2.1% not applicable

About 7 out of every 10 respondents (69.0%) said that some to a great deal of additional nutrition T/TA is needed.

One region stands out when the answers its respondents gave are compared to the results just described, and that is Region XI IMPD where 86.8% of those interviewed said that some to a great deal of additional nutrition T/TA is needed. This is a considerably higher percentage of response than the 'norm' of 69.0% described in the previous paragraph. It suggests a substantially higher desire for further nutrition T/TA among IMPD respondents than those in any other case study.

Secondly these same interviewees were queried regarding how much more psychological services T/TA they believed was needed to meet the needs of their program. Again, their choices of answers were "a great deal, quite a bit, some, a little, or none." Their responses are shown here in Table D79.

Table D79: Need for More Psychological Services TYTA

	REGION							
COUNT / ROW PCT / COL PCT / TOT PCT	I REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	2.1	1.1	4.1	5.1	6.1	10.1	11.1	
PSYCHIATRIST								
20.	4	13	11	12	6	9	12	82
A GREAT DEAL	11.0	15.9	13.4	12.2	9.8	11.0	20.3	12.2
	15.4	16.7	15.5	15.4	15.4	16.4	19.7	
	2.1	3.0	2.6	2.3	1.4	2.1	3.1	
21.	12	19	16	16	10	12	17	102
QUITE A BIT	11.8	18.6	15.7	15.7	9.8	11.8	16.7	9.4
	25.0	24.4	22.5	25.4	19.2	21.8	27.9	
	2.8	4.4	3.7	3.7	2.1	2.8	4.0	
22.	19	23	19	17	16	13	14	117
SOME	16.2	19.7	16.2	14.5	13.7	11.1	12.0	27.1
	39.6	29.5	27.1	27.0	30.8	23.6	23.0	
	4.4	5.4	3.9	4.0	3.7	3.0	3.3	
23.	5	5	3	3	2	4	0	27
A LITTLE	18.5	18.5	11.1	11.1	7.4	14.8	0.0	6.3
	10.4	6.4	4.3	4.8	3.8	7.3	0.0	
	1.2	1.2	0.7	0.7	0.5	0.9	0.0	
24.	1	6	1	4	6	7	0	25
NONE	4.0	24.0	4.0	16.0	24.0	28.0	0.0	5.8
	2.1	7.7	1.4	6.3	11.5	12.7	0.0	
	0.2	1.4	0.2	0.9	1.4	1.6	0.0	
98.	2	7	13	13	7	6	7	57
DON'T KNOW	3.5	12.3	22.8	22.8	12.3	10.5	12.3	13.3
	4.2	9.0	21.1	20.6	13.5	10.9	11.5	
	0.5	1.6	3.5	3.0	1.6	1.4	1.6	
99.	0	5	5	0	3	4	1	18
NOT APPL	0.0	27.8	27.8	0.0	16.7	22.2	5.6	4.2
	0.0	0.4	0.4	0.0	0.5	0.7	0.2	
	0.0	1.2	1.2	0.0	0.7	0.9	0.2	
COLUMN	48	78	71	63	52	55	61	426

Considering all responses across the seven regions together, it appears that frequencies of responses could be clustered in this way:

43.0% said "a great deal" or "quite a bit" of additional psych-services T/TA is needed

27.3% said "some" additional T/TA is needed

12.1% said only "a little" or "none" is needed

17.5% said "don't know" or "not applicable"

As happened with the previous item on additional nutrition T/TA, about 7 out of every 10 respondents (70.3%) reported that some to a great deal of additional psychological services is needed.

Once more Region XI IMPD respondents answered more often than those in any of the other 6 regions that they needed some to a great deal of extra psychological services T/TA. Their rate of response was 87% vs. the aggregated 'norm' of 70.3% Region II New York interviewees were almost as frequent in answering "a great deal, quite a bit, or some," in that their rate of response was 83.4%. This figure represents a sharp rise too over the number of Region II persons (62.5%) who gave similar answers to the nutrition T/TA question, suggesting a significantly higher wish among that part of the sample for psychological services as opposed to nutrition T/TA.

Third and lastly, on the subject of special T/TA content areas, these same people were queried on the subject of needed handicapped services T/TA. As was the case in the previous 2 areas of questioning (nutrition and psychological services) they were all asked how much more T/TA for handicapped services they felt it was needed to meet the needs of their program -- and they were given the same five replies as possible responses: "a great deal, quite a bit, some, a little, or none." Their answers are displayed here in Table D80.

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Table D80: Need for More Handicapped Services T/TA (DSP n=428)

HCAPTTA	REGION	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	COUNT	2.1	3.1	4.1	5.1	6.1	10.1	11.1	
20.	ROW PCT	10	17	20	14	10	12	24	107
	COL PCT	9.3	15.9	18.7	13.1	9.3	11.2	22.4	25.0
	TOT PCT	20.8	21.8	28.2	22.2	15.2	21.8	30.3	
		2.3	4.0	4.7	3.3	2.3	2.8	5.6	
21.		21	20	12	13	11	12	14	103
		20.4	19.4	11.7	12.6	10.7	11.7	13.6	24.1
		43.8	25.6	16.9	20.6	21.2	21.8	23.7	
		4.9	4.7	2.8	3.0	2.6	2.8	3.3	
22.		13	10	16	20	11	6	13	94
		13.8	12.8	22.5	31.3	21.2	13.6	30.2	22.0
		27.1	12.8	22.5	31.7	21.2	10.9	21.3	
		3.0	2.3	4.2	4.7	2.6	1.4	3.0	
23.		1	7	3	3	4	5	1	24
		4.2	29.2	12.5	12.5	16.7	20.8	4.2	5.6
		2.1	9.0	4.2	4.8	7.7	9.1	1.6	
		0.2	1.6	0.7	0.7	0.9	1.2	0.2	
24.		2	3	7	4	5	8	1	30
		6.7	10.0	23.3	13.3	16.7	26.7	3.3	7.0
		4.2	3.8	9.9	6.3	9.6	14.5	1.6	
		0.5	0.7	1.6	0.9	1.2	1.9	0.2	
88.		4	5	5	8	6	9	7	46
		8.7	10.9	17.4	17.4	10.9	19.6	15.2	10.7
		8.3	6.4	11.3	12.7	9.6	16.4	11.5	
		0.9	1.2	1.9	1.9	1.2	2.1	1.6	
99.		0	10	3	1	5	3	1	24
		0.0	41.7	12.5	4.2	25.0	12.5	4.2	5.6
		0.0	12.8	4.2	1.6	11.5	5.5	1.6	
		0.0	2.3	0.7	0.2	1.4	2.7	0.2	
COLUMN		48	78	71	63	52	55	61	428

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Considering all answers across the various case studies together, it seems apparent that the responses could be viewed in this manner:

one-half : high need for more handicapped T/TA

49.1% — 25.0% a great deal; 24.1% quite a bit

one-fourth: some need for more handicapped T/TA

22.0% - some

one-eighth: a little or no need

12.6% — 5.6% a little; 7.0% none

one sixth: don't know or not applicable

16.3% — 10.7% don't know; 5.6% not applicable

For the third consecutive time (nutrition and psychological services being the first two) in these questions about special T/TA content areas, roughly 7 out of every 10 respondents (71.1%) believe that some to a great deal of additional handicapped services T/TA is needed. In itself that is significant. In conjunction with the previous lines of interviewing about nutrition and psychological services, it is a critical piece of information, strongly suggesting that a large consensus exists across the 7 regions for more T/TA in each of these 3 special content areas.

Regions XI IMPD and II New York, as was the case in the preceding question on psychological services, lead all the other regions in frequency of the responses "a great deal, quite a bit, and some" taken together -- 83.6% and 85.4% respectively vs. the 'norm' of 71.1%. This suggests once more that a significantly larger number of persons in these 2 regions interviewed believe they need more T/TA help in a specific content area (handicapped) than do those interviewed in the other 5 regions.

Given the fact that serving the handicapped has been such a major

thrust of Project Head Start in the past couple of years, several more questions on the subject were put to those being interviewed.

First of all they were asked to give a capsule judgement on what kinds of resources they currently had available to their program to give needed expertise and information about the handicapped. The results of this question have been synthesized and are demonstrated here in Table D81.

Table D81: Current T/TA Resources Available for Handicapped Services (DSP n=428)

Resource	#/% yes	#/% no
National Providers	54/12.6	374/87.4
Regional Providers	100/23.4	328/76.6
RTO/STO Network	61/14.3	367/85.7
Community Agencies	190/44.4	238/55.6
Private Consultants	97/22.7	331/77.3
Universities/Colleges	117/27.3	311/72.7
A-V & Written Materials	90/21.0	338/79.0
Other	62/14.5	366/85.5

This data suggests that over 4 out of 10 respondents (44.4%) believe they have a resource for needed expertise and information about the handicapped in their local community agencies. The next most frequently mentioned resource was universities or colleges (27.3%). No other resource was mentioned more than one-fourth of the time. Among the providers supposedly servicing the local programs directly, i.e., national and regional providers, and members of the RTO/STO network, the regional providers were mentioned most often (23.4% of the time) and the RTO/STO network and national providers considerably less often -- 14.3% and 12.6% of the time, respectively. In fact these 2 resources, in the overall scheme of things, seem to be the least useful resources available for the local programs in terms of helping with services for

the handicapped.

Once more, however, Head Start seems to be benefitting greatly from local community resources and succeeding well in bringing outside resources to bear on the solution of problems it faces. This finding compliments and reinforces the earlier ones that showed large portions of all local T/TA received were coming from non-Head Start sources.

There are some observable noteworthy regional variations in these findings. For example, 2 regions, III Philadelphia and V Chicago, exceed all the other 5, apparently, in utilizing their local community agencies as resources for expertise and information on the handicapped. Recall that the 'norm' across all 7 case studies was 44.4% frequency of response; in Philadelphia it was 57.7% and in Chicago 55.6%.

Two other regions, II New York, and VI Dallas, seem to do much better with their regional providers than the other 5 regions as far as help with handicapped services is concerned. Their rates of response to this source were 37.5% and 34.6% respectively vs the 'norm' of 23.4% across all the case studies.

One region, X Seattle, stand out as apparently getting more service from its state training officers than any other - its rate of response on this item was 25.5%. vs the 'norm' of only 14.3%.

Secondly, by way of probing even more with these 428 respondents on the subject of handicapped services, the question was asked; 'what particular kinds of T/TA services for the handicapped that you don't already receive that would benefit your program?" They could specify up to 3 things. The results of this question are shown here in Table D82.

Table D82: Other Areas of Need for Handicapped Services T/TA (DSP n=428)

Area of Need	Percent
1. Behavioral skills development	0.5
2. Behavioral modification/discipline	0.9
Specific Handicaps	
3. Mental retardation	1.9
4. Learning disabilities	1.2
5. Emotional disturbances	3.7
6. Speech defects	5.6
7. Physical handicaps	4.0
8. Working generally w/h handicapped	17.8
9. Identifying/screening handicapps	8.9
10. Working w/h parents of handicapped	6.3
11. Development/Getting resources and services	10.7
12. Nutritional implication	0.5
13. Specific handicaps (generally)	11.7
14. Community involvement	0.7
15. Adjustment of normal	0.9
16. Staff attitudes	1.2
17. Other (e.g., more training making toys, etc.)	8.6

Note: The percentages are based on the total number in the sample. However, 217 people answered don't know or not applicable to this question.

These various numbers can usefully be clustered into a few logical groupings, thereby making it easier to grasp the overall meaning of these findings. Three basic groupings, plus a catch-all one at the end for the more seldomly-mentioned items, seem to emerge:

General Handicapped Training (including screening techniques, utilization of resources - i.e., nos. 8,9,11)	37.4%
Specific Handicaps Training (including mental retardation, learning disabilities, emotional disturbances, speech defects, physical handicapps, i.e., nos. 3,7,13)	28.1%
'Needs of Others' Training (including parents, staff, normal children, community, i.e., nos. 10,14,15,16)	9.1%
Other items (nos. 1,2,12,17)	10.5%

What this shows is that of all the responses given to this question, nearly two-thirds of them (65.5%) were for more general training in working with handicapped (37.4%) and for more specialized training in dealing with particular handicapping conditions (28.4%). Also approximately 1/10 of the responses (9.1%) were votes for training in helping those in the life space around handicapped children, e.g., parents, normal children, staff, relate effectively with them.

Lastly, by way of rounding out the discussion on the special thrust Head Start has been making to deal with handicapped children, the question was asked of all these directors, staff, and parents: What types of problems occur in trying to identify and incorporate the handicapped into your program?" The persons interviewed were allowed to give up to 3 answers. These are presented now in Table D83:

Table D83: Problems in Identifying and Incorporating Handicapped (DSP n=428)

Problem	Percent
1. Recognizing, identifying handicaps	13.1
2. Recruiting handicapped (geography)	4.9
3. Unfamiliarity of staff with problem	13.6
4. Classroom adjustment	2.1
5. Adjustment of normal children	2.1
6. Behavioral problems (normal vs handicapped)	0.9
7. Parents' difficulty in acceptance	8.9
8. Lack of resources (referral, diagnostic, follow-up, materials etc.)	6.1
9. Lack of funds, facilities	13.8
10. Lack of staff	4.9
11. Lack of prior attention (medical, etc.)	2.6
12. Program inadequate (capacity load, etc.)	5.4
13. No problem - no handicapped	1.2
14. Speech-hearing difficulties	0.7
15. Community attitudes	0.9
16. None	4.7
17. Other	4.4

Note: The percentages are based on the total number in the sample, but 187 people answered don't know or not applicable to this question.

These responses reveal that several items consistently prompted the most frequent comment:

lack of funds, facilities	13.8%
(balloons #8 & 10 are combined with it, i.e. lack of resources, staff	24.8%
unfamiliarity of staff with problem	13.6%
difficulty in identifying handicapping conditions	13.1%

Not too much further behind in terms of frequency of response were:

parents' difficulty in accepting handicapping conditions of their children	8.9%
program's difficulty in serving all identified handicapped due to capacity load, etc.	5.4%
program's difficulty in recruiting handicapped in their geographic area	4.9%

A second form of analysis was then done on these data on special T/TA content areas described in this section -- bivariate analysis. Specifically, a cross tabulation of these results was run with data obtained both on level of satisfaction and perceived impact of T/TA by these same respondents, i.e., all 428 directors, staff, and parents.

Tables D84 and D85 have been constructed to display these cross tabulations:

Table D84: Cross-Tabulation of Amounts of Specific T/TA Needed in Program with Satisfaction Level of all T/TA Provided to Local Program (DSR)

Amount of Specific T/TA Needed in Program	Percent Indicating Level of T/TA Satisfaction and Amount of Specific T/TA Needed in Program			Total Percent indicating Amount of Specific T/TA Needed in Program
	Very Satis.	Satisfied	Dissatisfied/ Very Dissatis.	
Nutrition T/TA				(n=374)
A Great Deal	27.3	45.5	27.3	14.7
Quite a Bit	28.6	53.2	18.2	20.6
Some	32.7	53.6	13.7	40.9
A Little/None	41.6	52.8	5.6	23.8
Psychological Services T/TA				(n=345)
A Great Deal	23.1	48.7	28.2	22.6
Quite a Bit	28.4	51.0	20.6	29.6
Some	34.5	60.2	5.3	32.8
A Little/None	42.3	55.8	1.9	15.1
Handicapped Services T/TA				(n=349)
A Great Deal	29.8	46.2	24.0	29.8
Quite a Bit	24.8	58.4	16.8	28.9
Some	33.7	54.3	12.0	26.4
A Little/None	42.3	51.9	5.8	14.9

Note: The percents listed in the right-hand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

Table D85: Cross-Tabulation of Amounts of Specific T/TA Needed in Program with Extent of Impact from all T/TA Provided to Local Program (DSP)

Amount of Specific T/TA Needed in Program	Percent Indicating Extent of Impact and Amount of Specific T/TA Needed in Program				Total Percent Indicating Amount of Specific T/TA Needed In Program
	A Great Deal	Quite a Bit	Some	A Little/ None	
Nutrition T/TA					(n=367)
A Great Deal	29.8	24.6	22.8	22.8	15.5
Quite a Bit	34.7	22.7	36.0	6.7	20.4
Some	28.4	39.9	24.3	7.4	40.3
A Little/None	39.1	27.6	27.6	5.7	23.7
Psychological Services T/TA					(n=341)
A Great Deal	29.5	25.6	21.8	23.1	22.9
Quite a Bit	31.7	27.7	35.6	5.0	29.6
Some	26.1	40.5	28.8	4.5	32.6
A Little/None	47.1	25.5	25.5	2.0	15.0
Handicapped Services T/TA					(n=345)
A Great Deal	24.6	26.9	26.0	12.5	30.1
Quite A Bit	24.8	27.7	39.6	7.9	29.3
Some	28.6	37.4	25.3	8.8	26.4
A Little/None	44.9	28.6	22.4	4.1	14.2

Note: The percents listed in the right-hand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

Each of the special categories of T/TA - nutrition, psychological services, and handicapped services - reveal the same pattern when crossed with overall T/TA satisfaction. When the amount of special T/TA needed is high (a great deal and quite a bit), the positive satisfaction levels (very satisfied and satisfied) constitute a lower percentage of respondents compared to when the amount of special T/TA needed is low (some and a little/none). In fact, the greatest increase in percent occurs with those who were "very satisfied" and needed only "a little/none" T/TA. Conversely, the largest percentages of negative satisfaction (dissatisfed/very dissatisfied) are found among those who needed "a great deal" of the specific T/TA.

When each of these special categories of T/TA are crossed with overall T/TA impact, a similar inverse relationship exists. When the amount of special T/TA needed is high (a great deal and quite a bit), the percentage of respondents who indicated high T/TA impact (a great deal and quite a bit) is lower than when the amount of special T/TA needed is low (some and a little/none). And, at the opposite end of the scale, the greatest percentages of minimal impact (a little/none) occur among those who needed "a great deal" of the specific T/TA, although for handicapped services, the differential among the various amounts of T/TA needed is slight.

To recapitulate, an inverse relationship exists for amount of specific T/TA needed and satisfaction/impact levels. When the amount needed is high, lower percentages of positive satisfaction and high impact ratings appear; when the amount needed is low, higher percentages of positive satisfaction and high impact ratings occur.

Still another cross-tabulation was run, this time against the level of satisfaction with T/TA already received in each individual special category. The results are displayed here in Table D86:

Table D86. Cross-Tabulation of Extent of T/TA Needed and Satisfaction Level with T/TA Provided in Nutrition, Psychological Services, and Handicapped Services (DSP)

Extent of T/TA Needed in Each Special Category	Percent Indicating Satisfaction Level for and Amount of T/TA Needed in Each Special Category			Total Percent Indicating Amount of T/TA Needed in Each Special Category
	Very Satis.	Satis.	Dissat./Very Disatis.	
Nutrition T/TA				(n=365)
A Great Deal	16.1	41.1	42.9	15.3
Quite a Bit	10.3	50.0	39.7	21.4
Some	24.7	62.7	12.7	41.1
A Little/None	49.4	50.6	0.0	22.2
Pyschological Services T/TA				(n=339)
A Great Deal	9.0	26.9	64.1	23.0
Quite a Bit	8.2	42.3	49.5	28.6
Some	13.2	74.6	12.3	33.6
A Little/None	38.0	62.0	0.0	14.7
Handicapped Services T/TA				(n=348)
A Great Deal	10.6	36.5	52.9	29.9
Quite a Bit	5.0	49.0	46.0	28.7
Some	13.3	82.2	4.4	25.9
A Little/None	35.2	63.0	1.9	15.5

Note: The percents listed in the right-hand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

In this table keep in mind that the satisfaction ratings apply to each particular category of T/TA, not overall T/TA. For each category -nutrition, psychological, and handicapped services-, the highest percentages of "very satisfied" respondents are found among those who felt only "a little/none" T/TA was required. With the exception of the slight variance for "quite a bit" needed, the percentage indicating optimal satisfaction declines as the amount of T/TA needed increases. Conversely, the percentage indicating negative satisfaction (dissatisfied/very dissatisfied) increases dramatically as the amount of T/TA needed increases. For each cateogry of T/TA, those respondents who needed only "a little/none" indicated virtually 100% satisfaction (only for handicapped services did anyone express dissatisfaction - 1.9%).

Among those indicating a high need for each type T/TA ("a great deal" and "quite a bit"), psychological services has the lowest satisfaction and the highest dissatisfaction percentages. Handicapped services ranked next, followed by nutrition, in this pattern. Among those indicating a lower need ("some"), the percentage of dissatisfied respondents is approximately the same (12.0%) for both nutrition and psychological services, but drops for handicapped services (4.4%).

It appears that the greatest need is for T/TA in psychological services, followed by handicapped services, and finally, nutrition, as revealed by the large percentages expressing both high level of need and dissatisfaction.

Further discussion on this subject can be found in Section EI, on quality of T/TA, starting with Table EI2.

Summation of D6 Findings: Special Categories of T/TA

The main topical question addressed in this section was "how effectively are special content areas, i.e., nutrition, psychological services and handicapped needs, being addressed?" Data on this topic was collected at the local level only.

Director, staff, and parent interviewees were asked how much more nutrition, psychological services, and handicapped services T/TA was needed for their program. For each category of special T/TA approximately 7 out of 10 respondents said "some," "quite a bit", and "a great deal." (See Tables D78, D79, D80.) Isolating just the responses indicating high need ("quite a bit" and "a great deal"), the largest percentage is for handicapped T/TA (49.1%), next largest percentage for psychological services (43%) and then nutrition services T/TA (32.3%). One-half to one-third of our sample perceived their needs as high in these special categories of T/TA.

Because of the legislative mandate to incorporate the handicapped into the Head Start program, several other questions were asked to probe available resources, needs, and problems that affect this particular goal. As regards resources to give expertise and information about the handicapped, most respondents felt that community agencies (44.4%), universities or colleges (27.3%), and then regional providers (23.4%) were available to give needed assistance. Non-Head Start resources outweigh Head Start resources in this context (see Table D81).

Areas in which handicapped services are needed fall primarily into three categories: general handicapped training (working with handicapped, identifying and screening handicapped, and developing/getting resources and services), 37.4% frequency of response; specific handicapped training (mental retardation, learning disabilities, emotional disturbances, speech defects, physical handicaps, etc.), 28.1%; and needs of others training (parents, staff, normal children, community), 9.1%. Nearly two-thirds of the respondents indicate training needs in working

with the handicapped, generally and in terms of specific conditron. Approximately one-tenth of the respondents indicate training needs in working with others in the life space around the handicapped (see Table D82).

The problems encountered in trying to identify and incorporate handicapped children into the program can be grouped into the following categories: lack of support and supply (referral, diagnostic, follow-up resources; funds and facilities; staff; program capacity), 30.2%; untrained staff (nonfamiliarity with problem; difficulty in identifying handicapping conditions), 26.7%; parental difficulty in acceptance of handicapped child, 8.9%; teaching conditions (classroom adjustment; behavior of normal children vis-a-vis handicapped children), 5.1%; and recruitment problems because of geographic isolation, 4.9%. While the first category, lack of support and supply, relates more to problems that require substantial amounts of money to solve, most of the other categories relate to problems that increased training, requiring lesser amounts of money, could attempt to improve (see Table D83).

In both these questions relating to services needed and problems, more training and technical assistance is a constant.

Several variables were selected for the bivariate analysis. The amount of T/TA needed in each special category (nutrition, psychological services and handicapped services) was crossed with overall T/TA satisfaction and impact (see Tables D84 and D85). The same patterns occured for each special category. When the amount of special T/TA needed is high ("a great deal" and "quite a bit"), the percentages of respondents giving positive satisfaction ("very satisfied" and "satisfied") and high impact ("a great deal" and "quite a bit") ratings are lower. When the amount of special T/TA needed is low ("some," "a little" and "none"), the positive satisfaction and high impact ratings are higher.

The final bivariate analysis made was for extent of T/TA needed in each special category and satisfaction with T/TA already given in each

special category (see TAble D86). As would be expected, the highest percentages of positive satisfaction ("very satisfied" and "satisfied") occurred among respondents who felt the need for each special T/TA was low ("some," "a little", or "none"). As the need for special T/TA increased, the percentage of dissatisfied respondents also increased. Interestingly enough, of the three categories of special T/TA for which high need ("a great deal" and "quite a bit") was expressed, psychological services had the lowest satisfaction and highest dissatisfaction percentages, followed next by Handicapped services and then nutrition T/TA. This finding suggests that psychologoical services T/TA is needed more than handicapped services T/TA, or, possibly, that better quality T/TA is needed in psychological services.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

C. EXCELLENCE OF T/TA

The central question being addressed here is this -- "how excellent is the T/TA that is being received by Head Start?" In other words, at the end of the line, after the T/TA system has been managed and after the T/TA service has been delivered, how excellent is the final product? Excellence has been chosen as the key word here because it is a word that encompasses two concepts that are explored here: quality of T/TA and effects of T/TA. These two concepts are presumed, for purposes of this study, to be not necessarily intertwined. For example, it is possible to deliver T/TA of the highest quality to a consumer but find that it has little or no effect or impact because the consumer wasn't receptive to it. Conversely it seems possible to deliver some T/TA that is not particularly ingenious and find that its impact or effect is phenomenial because the consumer is extremely receptive. For these reasons the two concepts have been kept separate and then included in the larger term of "excellence".

The major question regarding excellence has been subdivided into two topical questions to correspond to the concepts of quality and effects. These topical questions are:

E1. Is the T/TA of high quality?

E2. What effects does the T/TA bring about?

What follows now is a discussion of KAI's findings and conclusions on each of these two questions. A summation will be presented at the end of each of the two sections.

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Section E1. Is the T/TA of High Quality?

This question is being posed in order to gain insight regarding the overall excellence of T/TA that is being provided to Project Head Start. The measures we have utilized to determine the quality of T/TA included levels of satisfaction on the part of the respondents and other appropriate continuous data rating scales on key items that pertain to T/TA after it has been delivered. In this section, the topic of quality of T/TA will be discussed at the national, regional, and local levels.

a. National Level Provider Responses

National level responses on this topic will be discussed only from the viewpoint of those national T/TA providers sampled.

Initially the 34 national providers were asked, "Generally, how satisfied or dissatisfied have you been with the training and technical assistance your organization has provided in the past year? Would you say very satisfied, satisfied, dissatisfied, very dissatisfied?" The frequency of each rating appears in the table below.

Table E1. Degree of Satisfaction with T/TA Provided National Providers (n=34)

Responses	Percent
Very Satisfied	35.3
Satisfied	50.0
Dissatisfied	5.9
Very Dissastisfied	--
Not Applicable	8.8

Not suprisingly, a majority of national providers were satisfied or very satisfied - a total of 85.3%. The not applicable responses were primarily (and appropriately) from ERIC respondents.

Moving from the general to the specific, we then sought data on a series of what we call key elements of training and technical assistance approach, content, and presentation - elements which are critical to effective T/TA at the local level. For each item in this next question, respondents were to rate the T/TA they had provided on a scale of 4,3,2, or 1, with 4 equalling the best and 1 the worst. That instruction was the only one given respondents in terms of labelling the numbers on this scale.

The question asked national providers was, "Considering all the training and technical assistance your organization has provided within the past year, how well would you say your organization did, on the average with regard to each of the following items: ..." (the items are listed in the first column here in Table E2):

Table E2. Ratings by National Provider on Key Elements of T/TA Presentation (n=34)

Key Elements of T/TA Presentation	Percent of National Providers on Each Point of Rating Scale					
	4	3	2	1	Don't know	Not applicable
1. Well-prepared for assigned T/TA activity	55.9	23.5	5.9	2.9	-	11.8
2. Familiar with Head Start purposes and needs	50.0	29.4	5.9	2.9	-	11.8
3. Presented subject matter at level appropriate to trainees' experience and education	47.1	38.2	2.9	-	2.9	8.8
4. Knew T/TA subjects thoroughly	41.2	38.2	5.9	-	5.9	8.8
5. Able to meet needs of participants	35.3	41.2	8.8	-	5.9	8.8
6. Communicated well with participants of T/TA activities	41.2	38.2	5.9	-	2.9	11.8
7. Used appropriate materials	55.9	29.4	2.9	-	-	11.8
8. Used appropriate T/TA techniques	41.2	41.2	5.9	-	-	11.8
9. Followed up after initial activity	35.3	20.6	23.5	5.9	2.9	11.8
10. Evaluated quality and effectiveness of T/TA	23.5	32.4	20.6	2.9	5.9	14.7
11. Manifested sensitivity to needs of poor	47.1	26.5	8.8	2.9	-	14.7

Remember that 4 equals the best possible rating and 1 the worst. At a glance it is apparent that the rating "1" was very little used. In most instances respondents rated each element "3" or "4." Let's look more closely at the variations.

For several key elements, the percentage of national providers rating their organization's T/TA as 4 (the best) clustered around the 50.0% level. These elements were: #1, well-prepared for assigned T/TA activity; #2, familiar with Head Start purposes and needs; #3, presented subject matter at level appropriate to trainees' experience and education; #7, used appropriate materials; and #11, manifested sensitivity to needs of poor. Near the 40.0% mark were #4, knew T/TA subjects thoroughly; #6, communicated well with participants of T/TA activities; and #8, used appropriate T/TA techniques. Follow-up, #9, and ability to meet participants' needs, #5, came out at the 35.0% level, while evaluation of quality and effectiveness of T/TA, #10, was low with slightly less than 25.0% of the respondents rating that item "4."

It is apparent that, among all these elements, only two, follow-up and evaluation (#9 and #10), received a significant proportion of "2" ratings (23.5% and 20.6% respectively). Overall, national providers rate their T/TA very much on the positive side.

b. Regional Level Responses

Regional level responses on this topic of quality of T/TA like all other topics in this chapter, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1.) Regional Office Responses

These responses are further divided into two parts: an integrated analysis of responses from all 11 regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter.

a.) Aggregated Analysis of all 11 Regions.

(See Chapter II for an explanation of the selection process for interviewees in the Regional Offices)

Based on an analysis of the aggregated responses of all 64 officials in eleven regions, data indicates a fairly high level of satisfaction with the quality of both the training and the technical assistance offered by T/TA providers within the past year. Only a few indicated dissatisfaction regarding both the training and technical assistance which, in this case, were judged separately by all respondents.

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study" Regional Office on the topic of T/TA quality. (See Chapter II for an explanation about the selection of the "case studies").

NEW YORK (II)

Although data in this region was sketchy in this dimension, there was no indication of dissatisfaction with either the training or technical assistance provided within the past year.

PHILADELPHIA (III)

Data from Region III indicates a greater satisfaction with the training offered by T/TA providers within the past year than with the technical assistance offered, but generally there was satisfaction with both.

ATLANTA (IV)

When considered in its totality, Region IV staff viewed the entire T/TA process as one in which they were "Satisfied" or "Very Satisfied" (on a scale of Very Satisfied/Satisfied, Dissatisfied/ Very Dissatisfied).

CHICAGO (V)

Of the respondents indicating satisfaction with the training offered by T/TA providers over the past year, one person qualified his satisfaction rating by saying that the system and/or money available did not allow enough areas of T/TA to be address.

One respondent in Region V said he was "Dissatisfied" with the technical assistance offered in the past year by TA providers. He gave as his reason for this dissatisfaction his feeling that providers did not have the technical knowledge of policy requirements and procedures regarding Head Start to provide satisfactory technical assistance.

DALLAS (VI)

The respondents in Region VI indicated they were "Satisfied" with both the training and the technical assistance offered by T/TA providers within the past year.

SEATTLE (X)

On a scale of Very Satisfied/Satisfied/Dissatisfied/Very Dissatisfied/Unable to Answer, respondents in Region X were generally satisfied with the training offered by T/TA providers in the past year. However, all noted an exception to this rating for one state, which received a "Very Dissatisfied" rating.

The judgment was the same for technical assistance offered in Region X--all satisfied except for one state in which TA was judged to be very poor.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

More respondents in the IMPD region were dissatisfied with both the training and technical assistance offered by T/TA providers within the past year than were satisfied. The reason given was that too many areas of T/TA were being missed by providers who do not visit the reservations often enough.

2) Regional Provider Responses

Presented in this section is an analysis of the responses received from the 77 regional providers interviewed (group two) on the subject of quality of T/TA. None of the RTO/STO network (group one) providers were interviewed on this topic. Regional variations in these data will be highlighted as appropriate.

As was true with the national providers, regional providers were asked, "Generally, how satisfied or dissatisfied have you been with the training and technical assistance your organization has provided in the past year? Would you say very satisfied, satisfied, dissatisfied, very dissatisfied?" In Table E 3; we see that nearly all providers were either very satisfied or satisfied. These percentages are almost exactly the same as for national providers (35.3% and 50.0%).

Table E 3. Degree of Satisfaction with T/TA Provided Regional Provider. (n=77)

RESPONSES	PERCENT
Very Satisfied	36.4
Satisfied	55.8
Dissatisfied	6.5
Very Dissatisfied	1.3

NOTE: COMPARE THIS TABLE WITH E 1 ON NATIONAL PROVIDERS

A few regional differences appear. The "norm" for very satisfied was 36.4%; Region II (New York) and VI (Dallas) providers were higher (50.0% and 57.1% respectively), while Region V (Chicago) and XI (IMPD) providers were lower (25.0% and 10.0% respectively). With one exception, virtually all the remaining providers in each region said they were satisfied. The exception to this pattern is found in Region V, in which half the providers sampled (50.0%) said they were dissatisfied, compared to the "norm" of 6.5%. These providers from Region V constituted all but one of the providers indicating dissatisfaction, and that frequency of

response is probably attributable to the difficulty the regional office has had in implementing its new T/TA delivery system. The distribution of monies to T/TA providers was held up for some time while the intricacies of working out the state and multi-state provider contracts were solved. Thus, the level of T/TA activity apparently declined during that time.

Another measure of the quality of T/TA was sought through on a series of what we call key elements of training and technical assistance approach, content, and presentation - elements which are critical to effective T/TA at the local level. For each item in this next question, respondents were to rate the T/TA they had provided on a scale of 4, 3, 2, or 1, with 4 equalling the best and 1 the worst. That instruction was the only one given respondents in terms of labelling the numbers of this scale.

The question asked regional providers was, "Considering all the training and technical assistance your organization has provided within the past year, how well would you say your organization did, on the average, with regard to each of the following items. (The items are listed in the first column of Table E 4 on the following page.)

Regional providers revealed more variation on these elements than did national providers (see Table E 2). A majority of regional providers rated their effort "4" (the best) on most of these key elements, in contrast with national providers. Familiarity with Head Start purposes and needs (#2), sensitivity to the needs of the poor (#11), and thorough knowledge of T/TA subjects (#4) ranged from 84.4% to 70.1%. At the lower end of the spectrum with the "4" rating were #5, ability to meet needs of participants (45.5%), #10, evaluation of quality and effectiveness of T/TA (37.7%), and #9, follow-up after initial activity (36.4%). It is on these latter two elements that an increase in

Table E 7. Ratings by Regional Providers
Key Elements of T/TA Presentation (n-77)

KEY ELEMENTS OF T/TA PRESENTATION	PERCENT OF REGIONAL PROVIDERS ON EACH POINT OF RATING SCALE*					
	4	3	2	1	Don't Know	Not Applicable
Well-prepared for assigned T/TA activity	67.5	27.3	1.3	--	1.3	2.6
Familiar with Head Start purposes and needs	84.4	13.0	1.3	--	1.3	--
Presented subject matter at level appropriate to trainees' experience and education	61.0	35.1	1.3	--	1.3	1.3
Knew T/TA subjects thoroughly	70.1	27.3	1.3	--	1.3	--
Able to meet needs of participants	45.5	50.6	1.3	--	1.3	1.3
Communicated well with participants of T/TA activities	67.5	29.9	--	--	1.3	1.3
Used appropriate materials	67.5	24.7	3.9	--	2.6	1.3
Used appropriate T/TA techniques	63.6	31.2	2.6	--	1.3	1.3
Followed up after initial activity	36.4	40.3	15.6	2.6	1.3	3.9
Evaluated quality and effectiveness of T/TA	37.7	51.9	9.1	--	1.3	--
Manifested sensitivity to needs of poor	77.9	18.2	--	--	1.3	2.6

*4 equals the best, 1 the worst.

NOTE: COMPARE THIS TABLE TO E 2 ON NATIONAL PROVIDERS.

the percentage of "2" ratings appears. This pattern parallels that occurring with national providers, although the percentage of national providers giving a "2" rating is higher than for regional providers (#9, 23.5% vs. 15.6%; #10, 20.6% vs. 9.1%). Follow-up and evaluation of T/TA quality and effectiveness are most difficult to effect and do really well for both regional and national providers.

Both elements, follow-up, and evaluation, reveal some regional differences. For follow-up, most providers did rate their organization's efforts either "3" or "4". Among those who rated it lower, ("2", for which the "norm" was 5.6%), Region II providers were not represented at all (0.0%), while 30.0% of Region XI (IMPD) providers were. For evaluation, again the majority of providers rated their activity "3" or "4", but 9.1% rated it "2". No Region II or XI providers were represented (0.0%), but higher than the "norm" were 21.4% of Region III (Philadelphia) providers.

A review of each region's provider ratings shows a number of variations above and below the "norm" for the "4" rating for each element (See Table E 5). But they can be summarized as follows:

- Region II (New York) providers were above the norm on every element. On only two elements (#5 and #9) were there less than 100.0% of these providers giving the rating "4".

- Region III (Philadelphia) providers were above the norm for "4" on element #1, below the norm on #3, #5, and #10, and at or near the norm on all others.

- Region IV (Atlanta) providers were below the "4" norm for elements #1, #4, and #11, and at or near the norm on all others.

- Region V (Chicago) providers were higher than the norm for "4" on elements #2, #4, #8, and #9, lower on #3, #6, and #7, and at or near the norm on all others.

- Region VI (Dallas) providers were above the norm for "4" on all elements except #2, #4, #6, and #7, for which they were at or near the norm.

- Region X (Seattle) providers were below the norm for "4" on elements #1, #3, #4, #6, #7, #9, #10, and #11, and at or near the norm on the others.

- Region XI (IMPD) providers were above the norm for "4" on elements #3 and #11, lower on #8 and #10, and at or near the norm on all other elements.

Table E 5. Comparison of Regional Providers in Each "Case Study Region" Rating Each Key Element of T/TA Presentation as "4" (the Best)

ELEMENT #	NORM FOR "4" RATING (THE BEST) ON EACH ELEMENT	PERCENT OF EACH REGION'S PROVIDERS RATING "4" (THE BEST) ON EACH ELEMENT*						
		II (n=4)	III (n=14)	IV (n=18)	V (n=8)	VI (n=14)	X (n=9)	XI (n=10)
1	67.5	100.0	78.6	44.4	75.0	85.7	55.6	60.0
2	84.4	100.0	78.6	77.8	100.0	85.7	77.8	90.0
3	61.0	100.0	42.9	61.1	37.5	78.6	44.4	80.0
4	70.1	100.0	78.6	55.6	87.5	78.6	55.6	60.0
5	45.5	75.0	21.4	44.4	37.5	71.4	44.4	40.0
6	67.5	100.0	78.6	66.7	37.5	78.6	44.4	70.0
7	67.5	100.0	71.4	72.2	50.0	71.4	44.4	70.0
8	63.6	100.0	64.3	61.1	75.0	85.7	55.6	20.0
9	36.4	50.0	28.6	27.8	50.0	57.1	22.2	30.0
10	37.7	100.0	14.3	44.4	37.5	57.1	22.2	20.0
11	77.9	100.0	85.7	66.7	75.0	92.9	44.4	90.0

*Except as noted in the preceding discussion, most providers in each region who did not rate these elements as "4", the best possible rating, rated them "3"; the next highest rating.

c) Local Level Responses

Local level responses on this topic of quality of T/TA, as has been the case with all other preceding topics in this chapter, are discussed first from the viewpoint of directors, staff, parents, and (where appropriate) community leaders associated with the thirty Head Start programs sampled, and then from that of local level T/TA providers.

1. Local Program Responses

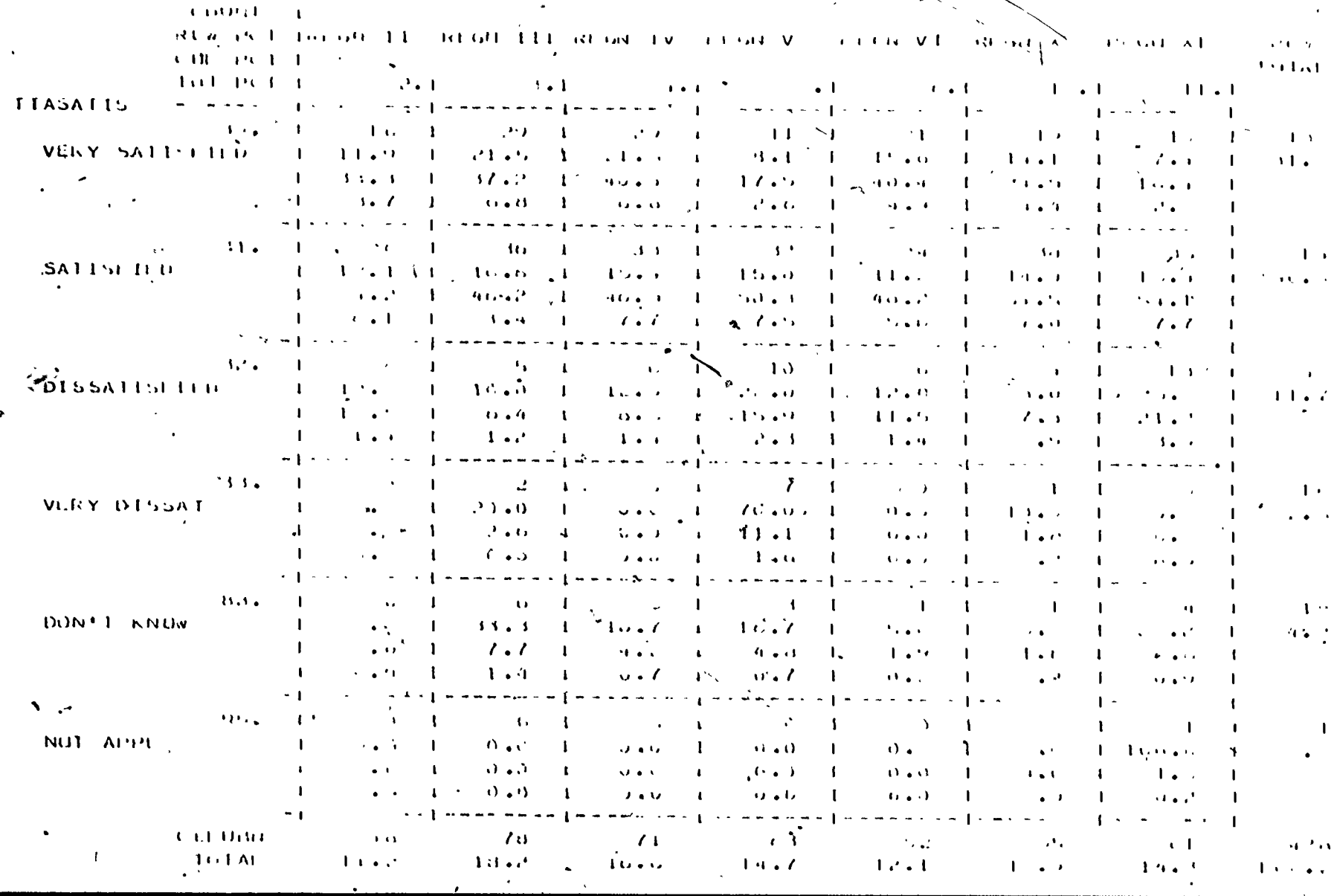
Project staff interviewed a total of 428 directors, staff, and parents (see Chapter II for an explanation of the selection process utilized.)

These respondents were asked to begin the portion of the interview on the quality of T/TA received with how satisfied or dissatisfied they have been with the T/TA their program received in the past year. They were given four possible responses: Very Satisfied, Satisfied, Dissatisfied, or Very Dissatisfied. Their answers are displayed in Table E 6 on the following page.

The most obvious finding here is that four out of five respondents (81.5%) gave answers in the positive range, i.e., either satisfied (50.0%) or very satisfied (31.5%) and only one-seventh of the interviews (14%) gave answers in the negative range, i.e. either dissatisfied (11.7%) or very dissatisfied (2.3%).

Regional variations - considering only percentages of positive responses - look like this, going from the region with the most frequent positive answers down to the one with the least.

Table E 6. Degree of Satisfaction With T/TA Provided: Directors, Staff, Parents (n=428)



Region X	Seattle	89.0% satisfied/very satisfied
Region II	New York	87.5% satisfied/very satisfied
Region IV	Atlanta	87.3% satisfied/very satisfied
Region VI	Dallas	86.6% satisfied/very satisfied
Region III	Philadelphia	83.4% satisfied/very satisfied
"NORM"		81.5% satisfied/very satisfied
Region XI	IMPD	70.5% satisfied/very satisfied
Region V	Chicago	68.3% satisfied/very satisfied

This same question on satisfaction with T/TA received by the local program was also put to the community leaders. Their answers are arrayed on Table E 7 on the following page.

As with the directors, staff, and parents, the most obvious finding is that four out of five respondents (82.8%) gave answers in the positive range, i.e., either satisfied (50.3%) or very satisfied (32.5%).

Regional variations - again considering only percentages of positive responses - look like this, once more going from the region with the most frequent positive answers down to the one with the least.

Region XI	IMPD	100.0% satisfied/very satisfied
Region III	Philadelphia	96.1% satisfied/very satisfied
Region II	New York	93.4% satisfied/very satisfied
"NORM"		82.8% satisfied/very satisfied
Region V	Chicago	81.4% satisfied/very satisfied
Region VI	Dallas	78.9% satisfied/very satisfied
Region IV	Atlanta	74.1% satisfied/very satisfied
Region X	Seattle	60.0% satified/very satisfied

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Table E.7. Degree of Satisfaction with T/TA Provided: Community Leaders (n=162)

SATWHS	REGN II	REGN III	REGN IV	REGN V	REGN VI	REGN X	REGN XI	ROW TOTAL
	2.0	3.0	4.0	5.0	6.0	10.0	11.0	
1.0 VERY SATISFIED	7	9	6	9	8	5	5	49
	14.3	18.4	12.2	18.4	16.3	10.2	10.2	30.5
	46.7	34.6	22.2	33.3	42.1	25.0	29.4	
	4.3	5.6	3.7	5.6	4.9	3.1	3.1	
2.0 SATISFIED	7	16	14	13	7	7	12	76
	9.2	21.1	18.4	17.1	9.2	9.2	15.8	46.9
	46.7	61.5	51.9	48.1	36.8	35.0	70.6	
	4.3	9.9	8.6	8.0	4.3	4.3	7.4	
3.0 DISSATISFIED	0	0	1	1	3	3	0	8
	0.0	0.0	12.5	12.5	37.5	37.5	0.0	4.9
	0.0	0.0	3.7	3.7	15.8	15.0	0.0	
	0.0	0.0	0.7	0.7	2.0	2.0	0.0	
4.0 VERY DISSATISFIED	0	0	0	1	1	1	0	3
	0.0	0.0	0.0	33.3	33.3	33.3	0.0	1.9
	0.0	0.0	0.0	3.7	5.3	5.0	0.0	
	0.0	0.0	0.0	0.7	0.7	0.7	0.0	
5.0 DON'T KNOW	1	2	6	2	0	3	0	14
	7.7	7.7	46.2	15.4	0.0	23.1	0.0	8.6
	6.7	3.8	22.2	7.4	0.0	15.0	0.0	
	0.7	0.7	4.0	1.3	0.0	2.0	0.0	
8.0 NOT APPL	0	0	0	1	0	1	0	2
	0.0	0.0	0.0	50.0	0.0	50.0	0.0	1.3
	0.0	0.0	0.0	3.7	0.0	5.0	0.0	
	0.0	0.0	0.0	0.7	0.0	0.7	0.0	
COLUMN TOTAL	15	26	27	27	19	20	17	151
	9.9	17.2	17.9	17.9	12.6	13.2	11.3	100.0

Note the dramatic reversals from the previous listing of directors, staff, and parents' response - frequencies in regions X (Seattle) and X (IMPD). In those two regions the satisfaction with T/TA seems to differ drastically from the directors, staff, parent category to the community leader category.

Another noteworthy finding is that three regions, II (New York), III (Philadelphia), and XI (IMPD), each had no community leaders who reported being dissatisfied with T/TA received by the local program with which they are associated.

KAI interviewers then attempted to get more specific and precise insights into the perceptions of the directors, staff, and parents about the quality of T/TA received. They asked each person interviewed a series of questions about various key elements of the services delivered by their T/TA providers. For example, each person was asked "how well prepared for assigned T/TA activity were your providers on the average -- would you say 4, 3, 2, or 1?" Four was the best, one, the worst, response. Presented in this next Table, E 8, are the results of this questioning. The questions are listed in the left hand (first) column, the four possible responses in the next column, and then the percentages representing frequency of response.

Several key findings emerge from this table:

- providers received the greatest proportion of high ratings overall on:

  --familiarity with Head Start program purposes and needs

  53% "4s" (best); 80.6% "4s" and "3s"

  --knowledge of T/TA subjects

  53.7% "4s" (best); 80.1% "4s" and "3s"

  --appropriateness of materials used

  49.8% "4s" (best); 78.8% "4s" and "3s"

Table E 8. Ratings by Director, Staff, and Parents Respondents Elements of T/TA Presentation (n=428)

Key Elements of T/TA Presentation	Percent of Respondents on Each Point of Rating Scale*			
	4	3	2	1
1. Well-prepared for assigned T/TA activity	44.0	33.9	7.9	1.4
2. Familiar with Head Start purposes and needs	53.3	27.3	5.8	0.7
3. Presented subject matter at level appropriate to trainees' experience and education	44.6	31.5	9.1	2.1
4. Knew T/TA subjects thoroughly	53.7	26.4	5.8	0.7
5. Able to meet needs of participants	38.1	36.0	12.4	1.9
6. Communicated well with participants of T/TA activities	44.2	30.8	11.7	1.2
7. Used appropriate materials	49.8	29.0	7.9	0.9
8. Used appropriate T/TA techniques	40.9	32.0	7.7	0.9
9. Followed up after initial activity	27.8	25.5	17.5	10.5
10. Evaluated quality and effectiveness of T/TA	29.4	27.3	14.0	4.9
11. Manifested sensitivity to needs of poor	42.1	27.3	11.7	3.3

*4 equals the best, 1 the worst..

- providers received the lowest proportion of high ratings overall on:

  --following-up after initial activity

  27.8% "4s" (best); 52.3% "4s" and "3s"

  --evaluation of quality and effectiveness of the work

  29.4% "4s" (best); 56.7% "4s" and "3s"

Several notable regional differences can be isolated:

- More Region VI Dallas respondents gave their providers the highest rating ("4") than any other region for familiarity with Head Start program purposes and needs - 63.5% vs "norm" of 53.3%.

- More Region V Chicago interviewees rated their providers "4" than any other region did for thoroughness of knowledge of their subjects - 68.3% vs "norm" of 53.7%.

- Region VI Dallas respondents said more frequently than any other region did that their providers used appropriate materials - 61.5% "4s" vs "norm" of 49.8%.

A second form of analysis of these data on key elements of T/TA delivered involved the cross-tabulation of the results just discussed with data obtained on the level of satisfaction with T/TA received by these same respondents, i.e., all 428 directors, staff, and parents (see Table E 6). This cross-tabulation is presented in Table E 9.

Looking first at those who rated provider T/TA presentation as "4" on each elements, it can be seen that:

- In every instance except one (#10, evaluated quality and effectiveness of T/TA), the percentage who said they were "very satisfied" was slightly lower than those who were "satisfied". However, the differential between these two satisfaction ratings across all elements is very small, averaging only 7%.

- The only instance in which this pattern is reversed is for #10, evaluation, when a slightly higher percentage were "very satisfied" compared to "satisfied", which suggests the importance of evaluation to high satisfaction.

- The total percentage of respondents who were "dissatisfied/very dissatisfied" is quite small for each elements, ranging from a low of 6.2% to a high of 11.9%.

Moving next to those who rated each element as "3", the following points can be made:

- For each element, the percentage of "very satisfied" respondents was much lower than those "satisfied". It is particularly acute for #7, "used appropriate materials." The differential between these two satisfaction levels across all elements averages 32%, in contrast to those rating each element "4", for which the differential averaged 7%.

- The percentage of "dissatisfied/very dissatisfied" respondents is slightly higher than those rating the characteristics "4" and expressing negative satisfaction. The highest percents occur for "used appropriate materials" and "familiar with Head Start program purposes and needs" (20.5% and 19.0%, respectively). The lowest dissatisfaction percents are found for "evaluation" (9.4%) and "follow-up" (7.5%), which points up that these aspects done well reduce dissatisfaction.

As regards those who rated each characteristic "2" or "1" (the lowest point on the scale), these findings were revealed:

- Comparatively speaking, very few respondents said they were "very satisfied". The major exception to this was for "follow-up (20.3%)." The majority said they were "satisfied". The differential between these two satisfaction levels averages 50% (as opposed to that for respondents making "3" ratings - 32%, and for "4" ratings - 7%).

- The total percentage of those who were "dissatisfied/very dissatisfied" is, in nearly every instance, much higher than for those making "3" or "4" ratings. The highest percentage occurs for "well-prepared for T/TA activity" (46.2%). This is overwhelming evidence as to its criticality to T/TA satisfaction. Follow-up, sensitivity to the needs of the poor, and familiarity with Head Start program were on the lower end of the percentages "dissatisfied/very dissatisfied" (26.3%, 26.2%, and 15.4%, respectively).

Table E 9. Cross-Tabulation of Key Elements of T/TA Presentation with Satisfaction Level of T/TA Provided to Local Program (DSP)

KEY ELEMENTS OF T/TA PRESENTATION	RATING SCALE	PERCENT INDICATING LEVEL OF T/TA SATISFACTION AT EACH POINT IN RATING SCALE FOR EACH ELEMENT			TOTAL PERCENT AT EACH POINT IN RATING SCALE FOR EACH ELEMENT
		Very Satisfied	Satisfied	Dissatisfied/ Very Dissatisfied	
Well-prepared for T/TA activity	4	42.2	49.2	8.6	50.7
	3	27.3	60.1	12.6	38.8 (n=3
	2/1	2.6	51.3	46.2	10.6
Familiar with Head Start program purposes and needs	4	39.6	49.3	11.1	61.3
	3	22.4	58.6	19.0	31.6 (n=3
	2/1	15.4	69.2	15.4	7.1
Presented subject matter at level appropriate to trainee's experience and education	4	41.8	49.2	9.0	51.4
	3	28.8	59.1	12.1	35.9 (n=3
	2/1	2.1	59.6	38.3	12.8
Knew T/TA subjects thoroughly	4	39.6	49.8	10.6	62.2
	3	24.1	60.7	15.2	30.7 (n=3
	2/1	0.0	65.4	34.6	7.1
Able to meet needs of participants	4	41.4	50.0	8.6	43.8
	3	33.1	54.1	12.8	40.0 (n=3
	2/1	5.0	63.3	31.7	16.2
Communicated well with participants of T/TA activities	4	42.5	47.8	9.7	50.5
	3	27.1	61.2	11.6	35.1 (n=3
	2/1	9.4	56.6	34.0	14.4
Used appropriate materials	4	43.5	50.2	6.2	56.9
	3	18.9	60.7	20.5	33.2 (n=3
	2/1	11.1	55.6	33.3	9.8
Used appropriate T/TA techniques	4	43.6	47.7	8.7	50.3
	3	24.4	60.7	14.8	39.5 (n=3
	2/1	14.3	48.6	37.1	10.2
Followed-up after initial activity	4	40.2	51.3	8.5	34.3
	3	34.9	57.5	7.5	31.1 (n=3
	2/1	20.3	53.4	26.3	34.6
Evaluated quality and effectiveness of T/TA	4	48.4	44.4	7.3	38.9
	3	30.8	59.8	9.4	36.7 (n=3
	2/1	9.0	57.7	33.3	24.5
Manifested sensitivity to needs of poor	4	42.6	45.5	11.9	49.9
	3	29.3	60.3	10.3	32.9 (n=3
	2/1	6.6	67.2	26.2	17.3

NOTE: THE PERCENTS LISTED IN THE RIGHT-HAND COLUMN ARE BASED ON VARYING NUMBERS OF RESPONDENTS, AS INDICATED. ALL DON'T KNOW AND NOT APPLICABLE RESPONSES HAVE BEEN OMITTED.

To summarize these findings, it can be stated that:

- Among those respondents who were "very satisfied" with T/TA, the highest percentages occur with those rating each element as "4," the best possible. As the ratings decline on the scale, so too do the percentages of "very satisfied" respondents.

- Conversely, the percentage of respondents rating each element as "2" or "1" manifest the highest proportion of negative satisfaction ("dissatisfied/very dissatisfied").

- As the ratings decline, the differential between "very satisfied" and "satisfied" respondents leaps (for "4" ratings - 7%; for "3" ratings - 32%; and for "2/1" ratings - 50%, which is another way to say that the lower the rating, the more likely respondents indicating positive satisfaction were "satisfied" rather than "very satisfied."

- Across all ratings (4; 3, 2, and 1), those elements with the highest percentages of "dissatisfied/very dissatisfied" respondents were first #1, well-prepared for T/TA activity, then #7 and #8, used appropriate materials and T/TA techniques, #3, presented subject matter at appropriate level, and #4, knew T/TA subjects thoroughly. These elements all relate to basic teaching principles and methodology. It is apparent that, from the viewpoint of these approximately 50 director, staff, and parent respondents (13.9% of total number), these areas require considerable improvement.

Next, specific questions relating to satisfaction or dissatisfaction with special content areas of T/TA were put to each of the interviewees. The reader should keep in mind the discussion of these special content areas in the previous section (D 6).

First, each person in this category was asked how satisfied or dissatisfied he or she was with the nutrition T/TA that was received in the past year. The possible answers were very satisfied, satisfied, dissatisfied, and very dissatisfied. The answers to this question are exhibited in Table E 10 which follows this page.

The initial overall finding to be noted is that seven out of ten respondents (69.9%) to this question are either "satisfied" or "very satisfied" with the nutrition T/TA they received in the past year. It should be recalled that eight of ten (81.5%) gave like answers to the question about overall satisfaction with T/TA, suggesting by comparison that these particular interviewees are slightly less satisfied with nutrition T/TA than with T/TA received overall.

Regional variations include:

- Region X (Seattle) respondents gave "satisfied" or "very satisfied" answers 80% of the time, the greatest frequency of response of any one of the individual case study regions.
- Region XI (IMPD) interviewees answered "satisfied" or "very satisfied" 52.4%, the lowest frequency of response of any of the seven case studies.

Secondly, these 428 respondents were asked how satisfied or dissatisfied they were with psychological services T/TA received in the past year. Once more the possible answers were very satisfied, satisfied, dissatisfied, very dissatisfied. The responses to this question are displayed in Table E 11 on the following page.

Fifty-five percent (55.3%) answered that they are either "satisfied" or "very satisfied" with psychological services T/TA received in the past year. This percentage represents a drop from both the 69.9% who gave similar answers regarding nutrition T/TA and the 81.5% regarding all T/TA considered as a whole.

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Table E 10. Satisfaction With Nutrition T/TA (DSP n=428)

NUTRISAT	REGION I	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION VII	REGION VIII	ROW TOTAL
10. VERY SATISFIED									
ROW PCT									
COL PCT									
TOT PCT									
11. SATISFIED									
ROW PCT									
COL PCT									
TOT PCT									
12. DISSATISFIED									
ROW PCT									
COL PCT									
TOT PCT									
13. VERY DISSAT									
ROW PCT									
COL PCT									
TOT PCT									
98. DON'T KNOW									
ROW PCT									
COL PCT									
TOT PCT									
99. NOT APPL									
ROW PCT									
COL PCT									
TOT PCT									
COLUMN TOTAL									

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Table E 11. Satisfaction With Psychological Services T/TA (DSP n=428)

PSYCHSAT	REGION I	REGION III	REGION IV	REGION V	REGION VI	REGION X	REGION XI	ROW TOTAL
30. VERY SATISFIED	4	12	11	7	2	0	4	40
	10.0	30.0	27.5	17.5	5.0	0.0	10.0	9.3
	13.3	15.4	15.5	11.1	15.4	0.0	7.1	
	0.9	2.8	2.6	1.6	0.5	0.0	0.9	
31. SATISFIED	23	35	29	39	7	4	37	194
	11.9	18.0	15.0	20.1	3.6	2.1	19.1	45.3
	76.7	44.9	40.8	61.9	26.9	80.0	66.1	
	5.4	8.2	6.8	9.3	1.6	0.9	8.6	
32. DISSATISFIED	1	15	16	14	0	1	10	91
	1.1	16.5	17.6	15.4	0.0	1.1	11.0	21.3
	3.3	19.2	29.6	22.2	0.0	20.0	17.9	
	0.2	3.5	3.8	3.3	0.0	0.5	2.3	
33. VERY DISSAT	1	5	1	4	2	0	1	24
	4.2	20.8	4.2	16.7	8.3	0.0	4.2	5.6
	3.3	6.4	1.9	6.3	3.8	0.0	1.8	
	0.2	1.2	0.2	0.9	0.5	0.0	0.2	
66. DON'T KNOW	1	7	10	15	9	0	7	60
	1.7	11.7	16.7	25.0	15.0	0.0	11.7	14.0
	3.3	9.0	19.2	23.8	17.3	0.0	12.5	
	0.2	1.6	2.3	3.5	2.1	0.0	1.6	
99. NOT APPL	0	4	3	0	2	0	1	10
	0.0	33.3	25.0	0.0	16.7	0.0	8.3	2.3
	0.0	5.1	5.8	0.0	3.8	0.0	1.8	
	0.0	0.9	0.7	0.0	0.5	0.0	0.2	
COLUMN TOTAL	30	78	71	63	52	5	61	428
	7.0	18.2	16.6	14.7	12.1	1.2	14.3	100.0

The only notable regional variation in this data occurs in Region XI (IMPD) where 45.9% of the respondents (vs. 55.3% of all the respondents across the seven case studies) answered either "satisfied" or "very satisfied."

Third and last, this group of interviewees was queried about their satisfaction or dissatisfaction with handicapped services T/TA. As was the case with the previous question on nutrition and psychological services T/TA the allowable responses were very satisfied, satisfied, dissatisfied, and very dissatisfied. The results of this question are shown on Table E 12 on the following page.

Fifty-eight percent (58.2%) responded that they are either "satisfied" or "very satisfied" with handicapped services T/TA received in the past year. This percentage is slightly above the psychological services one (55.3%) but still below the ones on satisfaction with nutrition T/TA (69.9%) and overall T/TA (81.5%).

Two noteworthy regional variations show up:

- Region IV (Atlanta) respondents answered "satisfied" or "very satisfied" 74.7% of the time, considerably above the 'norm' of 58.2% across all regions and above any other individual region.
- Region II (New York) interviewees gave "satisfied" or "very satisfied" as their answer 48% of the time, a frequency rate below any other individual region and below the 'norm' of 58.2% for all regions taken together.

Another attempt to get more specific and precise insights into the perceptions of the respondents about the quality of T/TA received was made by asking each interviewee about their satisfaction with national, regional, local, and non-Head Start sources of T/TA. The results of this line of questioning are presented in Table E 13.

Table E 12. Satisfaction With Handicapped Services T/TA (DSP n=428)

HCAPSAT	REGION I	REGION III	REGION IV	REGION V	REGION VI	REGION X	TOTAL	Row Total
5% VERY SATISFIED	2	8	3	28	4	5	5	49
	4.1%	16.7%	6.1%	57.1%	8.2%	4.1%	10.2%	11.4%
	9.5%	13.1%	25.0%	12.7%	7.7%	9.1%	11.7%	
	1.2%	1.9%	.7%	6.5%	.9%	1.2%	1.2%	
41% SATISFIED	21	31	32	99	27	29	39	201
	10.4%	15.4%	15.9%	49.3%	13.4%	14.4%	19.4%	47.0%
	95.5%	51.7%	88.9%	46.5%	51.9%	85.3%	91.7%	
	4.9%	7.2%	8.2%	23.1%	6.3%	6.8%	9.1%	
32% DISSATISFIED	13	17	6	13	11	1	1	61
	21.3%	27.9%	9.8%	21.3%	18.0%	1.6%	1.6%	14.3%
	37.1%	28.3%	16.7%	6.1%	21.2%	2.9%	1.7%	
	3.0%	4.0%	1.4%	2.8%	2.6%	.5%	.2%	
3% VERY DISSAT	2	3	0	1	1	1	0	10
	20.0%	30.0%	0.0%	10.0%	10.0%	10.0%	0.0%	2.3%
	5.7%	5.0%	0.0%	.5%	1.9%	2.9%	0.0%	
	.5%	.7%	0.0%	.2%	.2%	.2%	0.0%	
9% DON'T KNOW	4	8	7	16	7	2	0	44
	9.1%	18.2%	15.9%	36.4%	15.9%	4.5%	0.0%	10.3%
	11.4%	11.3%	19.4%	7.5%	13.5%	5.9%	0.0%	
	.9%	1.9%	1.4%	3.8%	1.9%	.5%	0.0%	
9% NOT APPL	1	2	1	1	2	2	4	13
	7.7%	15.4%	7.7%	7.7%	15.4%	15.4%	30.8%	3.0%
	2.9%	2.8%	2.8%	.5%	3.8%	5.9%	6.7%	
	.2%	.5%	.2%	.2%	.5%	.5%	.9%	
COLUMN TOTAL	35	70	36	213	52	34	60	428
	8.2%	16.4%	8.4%	49.8%	12.1%	7.9%	14.0%	100.0%

Table E 13. Comparative Levels of Satisfaction With T/TA Sources (Excluding All "Don't Know" or "Not Applicable" Responses, DSP)

Level of Satisfaction	National Providers (n=247) Number/Percent		Regional Providers (n=322) Number/Percent		Local Providers (n=111) (PA 20$) Number/Percent		Local Providers (N=66) (Prog. $) Number/Percent		Non-Head Start Sources (n=305) Number/Percent	
Very Satisfied	44	17.8	88	27.3	28	25.2	18	27.3	126	41.3
Satisfied	145	58.7	182	56.5	78	70.3	42	63.6	160	52.5
Subtotal	189	76.5	270	83.8	106	95.5	60	90.9	286	93.8
Dissatisfied	38	15.4	38	11.8	4	3.6	5	7.6	17	5.6
Very Dissatisfied	20	8.1	14	4.3	1	0.9	1	1.5	2	0.6
Subtotsl	58	23.5	52	16.1	5	4.5	6	9.1	19	6.2

The general conclusion that emerges from this data seems to be that the closer to the local level the source of the T/TA is, the more satisfied the consumers of it are likely to be. Considering all responses in the positive range, i.e., satisfied and very satisfied, together, the levels of satisfaction rank in this way:

1st	local-purchases T/TA (PA 20 funds)	95.5% Satisfaction
2nd	non-Head Start local sources	93.8% Satisfaction
3rd	Locally-purchased T/TA (Regular Program $)	90.9% Satisfaction
4th	regionally-provided T/TA	83.8% Satisfaction
5th	nationally-provided T/TA	76.5% Satisfaction

In other words, there is a very high level of satisfaction reported by these respondents with T/TA obtained at their own local level either through purchase (95.5%-PA20 and 90.9% - regular program dollars) or through donation from non-Head Start sources (93.8%), and then a lower level of satisfaction (83.8%) with T/TA from regional providers and a still lower level (76.5%) with T/TA from national providers.

Granted, there is a built-in bias in this data, in that the respondents would probably feel compelled, if even only subconsciously, to report the highest level of satisfaction with the T/TA for which they were directly responsible for purchasing. However, it still seems significant that the level of satisfaction rises when the amount of control over the arranging for the T/TA increases.

This, by the way, is probably one case where it is helpful to have binned together the responses of the directors, staff, and parents. The directors presumably would have the most to gain by answering satisfied or very satisfied to this question involving locally-purchased T/TA, but this tendency is checked or counter-

balanced by the staff and parents who presumably would not have such a stake. The finding that 95.5% (PA 20) are satisfied is all the stronger because it encompasses parents and staff as well as directors.

It also appears very noteworthy that such a high degree of satisfaction exists with T/TA provided free by non-Head Start sources. This tends to indicate a good working relationship between local Head Start programs and local sources of free T/TA such as community agencies, universities and colleges, etc. It further suggests both aggressive soliciting of such help by Head Start programs and willing supplying of the help from non-Head Start sources in the community.

Next, we ran a bivariate analysis crossing percent of and satisfaction with national provider T/TA, percent of and satisfaction with regional provider T/TA, etc. The only cross-tabulation which produced significant relationships was that for percent of and satisfaction with regional provider T/TA as is shown in Table E 14 on the following page.

Several noteworthy results emerged:

- For those rating satisfaction with regional provider T/TA as positive ("very satisfied", "satisfied"), the percentages rise as the amount of T/TA received increases. The only exception to this pattern is among the "satisfied" respondents when the amount of regional provider T/TA hits the 71-100% level, for which the percentage declines.
- For those rating satisfaction as negative ("dissatisfied"/ "very dissatisfied"), the percentages decline as the amount of T/TA received increases. Again, the only exception to this pattern occurs when T/TA amount is

Table E 14. Cross-Tabulation of Percent of and Satisfaction with Regional Provider T/TA (DSP n=428)

PCTREGNL	REGPRSAT			
COUNT / ROW PCT / COL PCT / TOT PCT	VERY SAT	SATISFIED	DISSAT-VERY DIS	ROW TOTAL
	30.1	31.1	32.1	
1. NONE THRU 10	5	21	23	49
	10.2	42.9	46.9	19.0
	6.5	15.6	50.0	
	1.9	8.1	8.9	
2. 11 THRU 30	14	37	12	63
	22.2	58.7	19.0	24.4
	18.2	27.4	26.1	
	5.4	14.3	4.7	
3. 31 THRU 50	22	43	7	72
	30.6	59.7	9.7	27.9
	28.6	31.9	15.2	
	8.5	16.7	2.7	
4. 51 THRU 70	7	12	0	19
	36.8	63.2	0.0	7.4
	9.1	8.9	0.0	
	2.7	4.7	0.0	
5. 71 THRU 100	29	22	4	55
	52.7	40.0	7.3	21.3
	37.7	16.3	8.7	
	11.2	8.5	1.6	
COLUMN TOTAL	77	135	46	258
	29.8	52.3	17.8	100.0

71-100%, for which the percentage slightly increases. The decrease is most marked when moving from the 0-10% level (46.9% negative satisfaction) to the 11-30% level (19.0%). Some amount of T/TA over the 0-10% level obviously greatly decreases the number of dissatisfaction responses.

- It is difficult to draw any conclusion from the shift that occurs among "satisfied" and "dissatisfied/very dissatisfied" percentages at the 71-100% level of T/TA provided. It seems to suggest that too much reliance on single-source T/TA is not the most favorable condition for increasing satisfaction, yet the largest percentage of "very satisfied" respondents occurs at this level. It may be that regional variations which do not appear in this table would shed some light on interpreting the shift.

2) Local Provider Responses

As was the case with the national and regional providers sampled, local providers were asked, "Generally how satisfied or dissatisfied have you been with the training and technical assistance your organization has provided in the past year? Would you say very satisfied, satisfied, dissatisfied, very dissatisfied?" Most local providers said satisfied (70.8%). This figure represents a higher percentage than for either regional (55.8%) or national (50.0%) providers, where more said "very satisfied." (See Tables E1 and E3.)

Table E 15. Degree of Satisfaction With T/TA Provided by Local Provider Organization (n=24)

Responses	Percent
Very Satisfied	16.7
Satisfied	70.8
Dissatisfied	4.1
Very Dissatisfied	4.1
Not Applicable	4.2

NOTE: Compare this Table with E1 (National Providers) and E3 (Regional Providers).

Two region's local providers vary from this "norm." One is Region III (Philadelphia) providers, all of whom (100.0%) said satisfied, and the other is Region XI (IMPD) providers, only 33.3% of whom said satisfied. All the other providers in Region XI said very satisfied.

The other measure of T/TA quality from local providers related to key elements of T/TA approach, content, and presentation critical to effective T/TA at the local program level. For each item in this next question, respondents were to rate the T/TA they had provided on a scale of 4, 3, 2, or 1. with 4 equalling the best and 1 the worst. That instruction was the only one given respondents in terms of labelling the numbers on this scale.

The question asked local providers was, "Considering all the training and technical assistance your organization has provided within the past year, how well would you say your organization did, on the average, with regard to each of the following items": (the items are listed in the first column here in Table E 16, following this page).

Local providers showed less tendency than regional providers to rate their efforts on each element as "4", the best. Four elements were at or slightly above the 50.0% level of respondents rating "4": Well-prepared for assigned T/TA activity (#1); knew T/TA subjects thoroughly (#4); communicated well with participants of T/TA activities (#6); and manifested sensitivity to the poor (#11). The lowest percentage of respondents rating their efforts as "4" appeared for #4, able to meet needs of participants (25.0%), #7, used appropriate materials (29.2%), #9, followed up after initial activity (20.8%), and #10. evaluated quality and effectiveness of T/TA (25.0%). On this last element, evaluation, a high percentage (29.2%) rated themselves "2". That percent response is higher than for either regional (15.6%) or national (20.6%) providers.

Table E 16. Ratings by Local Providers on Key Elements of T/TA Presentation (n=24)

KEY ELEMENTS OF T/TA PRESENTATION	PERCENT OF LOCAL PROVIDERS ON EACH POINT OF RATING SCALE*					
	4	3	2	1	Don't Know	Not Applicable
Well-prepared for assigned T/TA activity	50.0	37.5	4.2	--	--	8.3
Familiar with Head Start purposes and needs	45.8	37.5	8.3	--	--	8.3
Presented subject matter at level appropriate to trainees' experience and education	41.7	45.8	4.2	--	--	8.3
Knew T/TA subjects thoroughly	54.2	37.5	--	--	--	8.3
Able to meet needs of participants	25.0	58.3	4.2	4.2	--	8.3
Communicated well with participants of T/TA activities	50.0	37.5	--	4.2	--	8.3
Used appropriate materials	29.2	54.2	4.2	4.2	--	8.3
Used appropriate T/TA techniques	41.7	45.8	4.2	--	--	8.3
Followed-up after initial activity	20.8	54.2	8.3	8.3	--	8.3
Evaluated quality and effectiveness of T/TA	25.0	29.2	29.2	8.3	--	8.3
Manifested sensitivity to needs of poor	54.2	33.3	--	--	4.2	8.3

*"4" equalls the best, "1" the worst.

NOTE: COMPARE THIS TABLE TO E 2 (NATIONAL PROVIDERS) AND E 4 (REGIONAL PROVIDERS)

Local providers share with regional and national providers the difficulty of effecting follow-up and evaluation in the best possible fashion. In addition, they seem to feel less pleased with their use of appropriate materials.

Region-by-region variations occur on each of these elements of T/TA presented. One, evaluation, will be discussed here further to point out the differences occuring for the "2" rating, while the other elements will be summarized both in narrative and tabular form. For evaluation, a high percentage of local providers, relatively speaking, said their efforts were at the "2" point in the scale (29.2%). Two regions' providers were higher than this norm, III (Philadelphia) at 66.7%, and IV (Atlanta) at 44.4%. The remaining two regions' providers were lower, V (Chicago) at 11.1% and XI (IMPD) at 0.0%. Table E 17, on the following page, arrays the data for only the percent of providers rating each item "4", the best possible rating, and a summary of that data follows here.

- Region III (Philadelphia) providers were higher than the norm on elements #1, #2, #6, and #11, lower than the norm on elements #3, #4, #5, #7, #9, and #10.

- Region IV (Atlanta) providers were higher than norm for "4" on elements #3 and #11, lower on elements #1, #6, and #7, and at or near the norm on all others.

- Region V (Chicago) providers were higher than the norm on elements #7 and #8, lower on elements #2 and #11, and at or near the norm on all others.

- Region XI (IMPD) providers were higher than the norm for most elements: #1, #4, #5, #6, #7, #9, and #11, lower only on element #2, and at or near the norm on the remainder.

Table E 17. Comparison of Local Providers in Each Region Rating Each Element of T/TA Presentation as "4" (The Best)

Element #	"Norm" for 4 Rating (The Best) on Each Element	PERCENT OF EACH REGION'S LOCAL PROVIDERS RATING "4" (THE BEST) ON EACH ELEMENT*			
		III (n=3)	IV (n=9)	V (n=9)	XI (n=3)
1	50.0	66.7	33.3	44.4	100.0
2	45.8	100.0	44.4	33.3	33.3
3	41.7	0.0	55.6	44.4	33.3
4	54.2	33.3	55.6	55.6	66.7
5	25.0	0.0	22.2	22.2	66.7
6	50.0	100.0	22.2	44.4	100.0
7	29.2	0.0	11.1	44.4	66.7
8	41.7	33.3	33.3	55.6	33.3
9	20.8	0.0	22.2	11.1	66.7
10	25.0	0.0	33.3	22.2	33.3
11	54.2	66.7	66.7	33.3	66.7

*Except as noted in the preceding discussion, most providers in each region who did not rate these elements as "4", the best possible rating, rated them "3", the next hightest rating.

Summation of EI Findings: Quality of T/TA

The question at issue here was "Is the T/TA received of high quality?" This question was asked in order to gain insight into the overall excellence of T/TA being provided to Head Start.

The first measure of T/TA quality was sought through satisfaction level with the overall T/TA provided in the past year. All providers, local level personnel, and selected Regional Office staff gave ratings as to the degree of satisfaction/dissatisfaction.

Across all types of respondents, the totals of "very satisfied" and "satisfied" responses were in the ninth and tenth deciles, so satisfaction was high across the board. The distribution by type of respondent was 81.5% for local directors, staff, and parents; 82.8% for community leaders; 85.3% for national providers; 87.5% for local providers; and 92.2% for regional providers. Within these totals, responses from national and regional providers, local directors, staff, parents, and community leaders divided into approximately one-third "very satisfied" and one-half "satisfied." A shift occurred for local providers, however, in that only one-sixth were "very satisfied" and seven-tenths "satisfied." The range of "dissatisfied" and "very dissatisfied" responses was 5.9% for national providers to 14.0% for local directors, staff, and parents. Most totals hovered around the 8.0% mark, so the 14.0% represents a comparatively higher level. Since the question to providers asked satisfaction with T/TA "your organization has provided" and to others satisfaction with T/TA "your organization has provided" and to others satisfaction with T/TA "your program has received," it is likely that some inflation in provider responses occurs. There is a vested interest in answering positively; regional providers were on the high end of the positive satisfaction totals. As mentioned, however, local providers had the lowest total of "very satisfied" responses (16.7% vs. approximately 33:3% for all other respondents), so it would seem that as a group they perceive that more improvement is needed in the T/TA provided.

A second measure of quality T/TA related to what we call key elements of T/TA presentation. For ease of comparison, a table has been constructed (E18)

listing each of these key elements and presenting the percentage of each type of respondent rating each element as "4," the best possible rating. (The rating scale is 4 to 1, with 4 equalling the best and 1 the worst. In all instances, the majority of responses were "4" and "3." When a notable proportion of "2" or "1" responses appear, they will be highlighted. When two or more categories of respondents' answers clustered around the same percentage, that clustering was used informally as a norm against which to compare variations in other respondent categories. A plus sign shows a variation above the norm of two or more clusters and minus sign shows a variation down from the norm. For example, regional providers on the element of preparation, no. 1, are above the norm constituted when the national and local providers clustered in the sixth decile (50%-59%).

The percentages across all types of respondents tend to cluster at a particular level for each element. The data can be summarized as follows:

- National providers tend to be within the cluster of percentages on all items except #4, knew T/TA thoroughly, for which they are somewhat lower. Their responses tend to parallel those of directors, staff, and parents.
- Regional providers show a consistently higher proportion of "4" ratings than all other groups on all elements except #9, follow-up, for which they are within the cluster of percentages. They obviously perceive fulfilling their T/TA activities in a more positive way than any other group.
- Local providers tend to be within the clustered percentages on all elements except #5, able to meet needs of participants, #7, used approriate materials, and #9, follow-up, for which they are lower. Their responses on most items are close to those of national providers and directors, staff, and parents.

Table E 18. Percent of National, Regional, Local Providers, and Local Program Personnel Rating Each Key Element of T/TA Presentation as "4" (the Best)

Key Elements of T/TA Presentation	Percent of Each Type of Respondent Rating Each Key Element as "4" (the best)			
	National Providers (n=34)	Regional Providers (n=77)	Local Providers (n=24)	Directors, Staff, and Parents (n=428)
1. Well-prepared for assigned T/TA activity	55.9	67.5+	50.0	44.0-
2. Familiar with Head Start purposes and needs	50.0	84.4+	45.8	53.3
3. Presented subject matter at level appropriate to trainees' experience and education	47.1	61.0+	41.7	44.6
4. Knew T/TA subjects thoroughly	41.2-	70.1+	54.2	53.7
5. Able to meet needs of participants	35.3	45.5+	25.0-	38.1
6. Communicated well with participants	41.2	67.5+	50.0	44.2
7. Used appropriate materials	55.9	67.5+	29.2-	49.8
8. Used appropriate T/TA techniques	41.2	63.6+	41.7	40.9
9. Followed up after initial activity	35.3	36.4	20.8-	27.8
10. Evaluated quality and effectiveness of T/TA	23.5	37.7+	25.0	29.4
11. Manifested sensitivity to needs of poor	47.1	77.9+	54.2	42.1-

+ percentage is higher than the range where 2 or more categories of respondents tend to cluster

- percentage is lower than the range where 2 or more categories of respondents tend to cluster

- Directors, staff, and parents are within the clustered percentages on all elements except #1, well-prepared for assigned T/TA activity, and #11, manifested sensitivity to needs of poor; for which they are somewhat lower. More local respondents perceive a less than adequate fulfillment of these two elements than any other group.
- All respondents show comparatively low percentages of "4" ratings for #9, follow-up, and #10, evaluation. On both these elements, the percentages of "2" and "1" ratings rise in comparison to all other elements. These two critical areas are ones in which significant improvement is warranted.
- Directors, staff, and parent respondents show higher percentages of low ratings ("2" and "1") for #3, presented subject matter at appropriate level, #5, able to meet needs of participants, and #11, manifested sensivity to needs of poor. These areas are especially important to local program needs, and more local respondents perceive a less than adequate fulfillment of these two elements than any other group.

With the director, staff, and parents responses, a bivariate analysis was made with this series of key elements of T/TA presentation and overall T/TA satisfaction. A positive relationship exists between high ratings on each element ("4") and high satisfaction ("very satisfied") and low ratings on each element ("2/1") and dissatisfaction. That is, the highest percentage of "dissatisfied/very dissatisfied" respondents rated each element "2" and "1."

Director, staff, and parent respondents were asked about satisfaction with special T/TA in the areas of nutrition, psychological and handicapped services. For nutrition T/TA 69.9% were "very satisfied/satisfied"; for psychological services T/TA, 55.3%; and for handicapped T/TA, 58.2%. While a majority of respondents were satisfied, these findings indicate that, especially for the latter two categories, improved T/TA would be of benefit.

Finally, local program personnel gave satisfaction ratings on T/TA received from national, regional, and local providers, and non-Head Start sources. The percentage of respondents answering "very satisfied" and "satisfied" for each type were:

national providers	76.5%
regional providers	83.8%
local providers (PA 20 funds)	95.5%
local providers (program funds)	90.9%
non-Head Start sources	93.8%

It is apparent that 1) the closer to the local level the source of T/TA is, the greater the number of respondents expressing satisfaction, and 2) non-Head Start sources of T/TA provide highly satisfactory services, second only to PA-20 funded local providers.

A bivariate analysis crossing percent of and satisfaction with national provider T/TA, regional provider T/TA, etc. resulted in this general rule: as the amount of T/TA received increases, the percentage of satisfied respondents increases and the percentage of dissatisfied respondents decreases. For regional provider T/TA, however, the exception to the pattern occurs at the 71-100% level of T/TA received from this source, when the dissatisfaction percentage increases. At the 51-70% level, no respondents (0.0%) were dissatisfied, but at the 71-100% level, 7.3% were dissatisfied. The reason for this shift is unknown. In addition, the biggest shift in percentage of dissatisfied respondents occurs between the 0-10% level (46.9%) and 11-30% level (19.0%), so obviously, some amount of T/TA above the 10% level greatly decreases dissatisfaction.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

Section E2: What effects does the T/TA bring about?

This question also is being posed in order to gain insight regarding the overall excellence of T/TA that is being provided to Project Head Start.

T/TA should have a positive impact on improving the expertise of its target groups, i.e. Head Start officials, staff, parents, etc., and thereby have an effect on the entire operation of the program in terms of serving children better. The measures we have utilized to determine the effects of T/TA included perceived impact of T/TA received and other appropriate continuous data rating scales on key items that pertain to T/TA after it has been delivered. In this section, the topic of effects of T/TA will be discussed at the national, regional, and local levels.

a. National Level (Provider) Responses

National level responses on this topic will be discussed only from the viewpoint of those national T/TA providers sampled. We asked a series of questions aimed at measuring the effects of T/TA provided by the provider organizations. First, the question was put to national providers, "How much impact has the training and technical assistance your organization has provided in the past year had on improving the programs (regions) you serve? Would you say a great deal, quite a bit,

some, a little, or none?" The percentages for each response appear below:

Table E19. Extent of Impact of National Provider T/TA on Programs (Regions) Served (n=34)

Responses	Percent
A Great Deal	14.7
Quite a Bit	32.4
Some	29.4
A Little	2.9
None	5.9
Don't Know	5.9
Not Applicable	8.8

Nearly one-third of the respondents said "quite a bit" (32.4%). A slightly smaller group indicated "some" impact (29.4%). When the two responses "a great deal" and "quite a bit" are combined, almost half (47.1%) of the respondents are accounted for. Those on the negative side ("a little, none") constitute 8.8% of these providers.

The national providers were asked a series of questions about the effects of the T/TA they had provided in regard to meeting the needs of the local Head Start program, the staff, and the parents. They were to give ratings on the T/TA to each referent in terms of the T/TA being complete, practical, informative, and timely. Now, for each of these key characteristics, a scale of 4,3,2, and 1 was included, and the respondent was to rate each characteristic using this scale, with 4 equaling the best, and 1, the worst. If the interviewee had a question about the definition of one of these words (complete, practical, informative, and timely), the interviewer offered the particular definition given below.

Complete - adequate in covering the actual needs
Practical - useful in assisting their activities
Informative - clear in educating the participants
Timely - punctual in response to the actual needs

Table E20 presents the rating for each characteristic as it related to meeting the needs of the local program, of staff, and of parents.

Table E20. Ratings by National Providers on Key Characteristics of Their T/TA in Regard to Meeting the Needs of the Local Head Start Program, Staff, and Parents (n=34)

Characteristics	Rating Scale	Percent of National Providers on Each Point of Rating Scale for Each Recipient		
		Program	Staff	Parents
Complete	4	8.8	20.6	5.9
	3	32.4	38.2	11.8
	2	23.5	17.6	23.5
	1	8.8	2.9	11.8
	Don't Know	5.9	5.9	8.8
	Not Applicable	20.6	14.7	38.2
Practical	4	32.4	47.1	14.7
	3	35.3	26.5	23.5
	2	5.9	8.8	8.8
	1	2.9	--	5.9
	Don't Know	2.9	2.9	8.8
	Not Applicable	20.6	14.7	38.2
Informative	4	35.3	44.1	17.6
	3	29.4	32.4	20.6
	2	5.9	5.9	8.8
	1	2.9	--	5.9
	Don't Know	5.9	2.9	8.8
	Not Applicable	20.6	14.7	38.2
Timely	4	35.3	28.2	11.8
	3	23.5	29.4	20.6
	2	17.6	14.7	14.7
	1	--	--	5.9
	Don't Know	2.9	2.9	8.8
	Not Applicable	20.6	14.7	38.2

Before discussing these findings, an explanation of the don't know and not applicable answers should be offered. Some individuals were not involved at the local level in a way that made the interviewee feel it was appropriate to give a rating. The differences in the proportion of don't know and no applicable responses among the three categories, program, staff, and parents, reflect the differences in familiarity of national providers with each, and, as is evident in the table, the greatest percentages of don't know and not applicable answers appear in the rating for T/TA meeting parents' needs. Since the percentages listed are all based on the total number of respondents, comparisons are easily made among the different categories and ratings.

As regards meeting the needs of the program, staff, and parents, most of the respondents making ratings (excluding don't know and not applicable) gave "4" and "3" ratings to practical, complete, and timely T/TA provided. However, complete T/TA evidences a somewhat different pattern. The total number of respondents giving "4" and "3" ratings is much lower for each group (program, staff and parents) in comparison to every other characteristic. The proportion of "4" ratings for complete T/TA declined dramatically, and for parents' needs, the total of ratings "4" and "3" is lower (17.7%) than the total for "2" (23.5%).

In comparison to practical and informative, a higher frequency of "2" ratings appears for complete T/TA in regard to meeting the needs of the program, staff, and parents (23.5%, 17.6%, and 23.5% respectively), and for timely T/TA (19.6%, 14.7%, and 14.7% respectively). More providers expressed less confidence in these two characteristics of T/TA.

In order to get another measure of the effects of T/TA to both staff and parents, we asked national providers to tell us if the T/TA to each of these groups had led to better services for the children. The results of this question are displayed in Table 12, which is shown on the next page. The percent of providers responding positively was high for staff T/TA (82.4%), but much lower for parent T/TA (41.2%). Those who said

yes were then questioned as to the extent of better services to children,

Table E21. Better Services for Children As a Consequence of National Provider T/TA to Staff and to Parents (n=34)

Responses	Percent of Providers for Each T/TA Recipient	
	Staff	Parents
Yes	82.4	41.2
No	2.9	5.9
Don't Know	8.8	11.8
Not Applicable	5.9	41.2

according to the scale shown in the following table, E22:

Table E22. Extent of Better Services to Children Resulting From Staff and Parent T/TA Offered by National Providers (n=34)

Responses	Percent of Providers for Each T/TA Recipient	
	Staff	Parent
A Great Deal	29.4	11.8
Quite a Bit	23.5	2.9
Some	17.6	20.6
A Little	2.9	5.9
None	-	-
Don't Know/Not Applicable	26.5*	58.8

* For staff T/TA, 3 respondents who answered yes to preceding question were not able to indicate extent of better services to children, so they are included in this percent.

The percentage of respondents rating extent of better services to children as "a great deal" and "quite a bit" sharply declined from staff T/TA (52.9%) to parent T/TA (14.7%). The much higher number of don't know/not applicable responses for parent T/TA does not totally account for this difference, because 20.6% rated extent of better services, "some", a figure comparable to that for staff T/TA. It would appear that other factors, perhaps difficulty of or resistance to change on the part of the parents, negatively affect greater extent of better services for children through parent T/TA.

Those respondents who said better services to children were not a consequence of T/TA to staff and parents were asked to explain why not. The one respondent answering "no" to staff T/TA leading to better children services said the reason was that there was no follow-up to the T/TA given and that this problem is a recurring one in OCD T/TA activities. The two respondents answering "no" to parent T/TA leading to better services indicated it was because so little T/TA was given.

b. Regional Level Responses

Regional level responses on this type of effects of T/TA as are all other topics in this chapter, are discussed first from the viewpoint of Regional Office (RO) personnel and then from that of regional level T/TA providers.

1. Regional Office Responses

These responses are further divided into two parts: an integrated analysis of responses from all 11 regions and an individualized analysis of responses from each of the seven case study regions. This format for presenting RO responses will be followed throughout this chapter.

a) Aggregated analysis of all 11 regions

(See chapter II for an explanation of the selection process for interviewees in the Regional Offices)

Inquiry was made of Regional Office interviewees as to T/TA services from national providers. A list of the most frequently mentioned national T/TA providers across all regions, along with the effectiveness of each national provider, follows:

Table E23. Effectiveness of Specific National Providers: RO Respondents

Provider	Frequency of Response for Each Rating				
	Excellent	Very Good	Good	Fair	Poor
U.S. Department of Agriculture	1	1	1	1	2
American Academy of Pediatrics	7	8	3	4	
U.S. Public Health Service (Dental)	6	8	5	1	1

(n=64, many of whom did not respond)

Of these three national providers mentioned with some frequency, two, the American Academy of Pediatrics and U.S. Public Health Service, received a substantial proportion of high ratings ("excellent" and "very good")--68.2% and 66.7% respectively. Since approximately two-thirds of regional office respondents gave such high ratings (and most of the remaining respondents rated these providers effectiveness "good"), it is apparent that of all national providers mentioned, these two were regarded as most effective in fulfilling their T/TA tasks. No other providers received such endorsement.

Providers listed in the "other" category--generally used with comparatively low frequency--were:

American Medical Association
American Dietetic Association

American Psychological Association
FY 74 High Scope (CDA)
Huron Institute--CFRP
Home Start
University Research Corporation
TADS
HSST

The ratings on the effectiveness of these sources in the national provider T/TA process were evenly divided between the "Good" and "Fair" categories; one respondent ranked one provider as "Very Good." Almost all of the national provider services were offered rather than requested by the Regional Office.

Inquiry was also made of Regional Office staff as to whether any improvements are needed in the service given by these national providers. Answers are summarized as follows:

Table E24. Improvement Needed in National Providers: RO Respondents

Responses	Frequency of Response
Yes	12
No	7
No opinion	23

(n=64, 16 of whose answers were not solicited)

From those respondents who said "yes," the following types of improvements were mentioned:

- Better match of provider skills/expertise with regional needs
- More accessibility of providers
- Consolidation of efforts to avoid duplication

- More timely delivery of service
- Less by-passing of Regional Office which will allow greater RO input
- Greater knowledge and sensitivity by provider to policy thrusts of OHD and OCD.

Regional Office respondents were then asked to rate the effectiveness of regional providers. As many respondents rated effectiveness of regional providers highly ("excellent" and "very good") as did moderately (good). Overall regional office staff perceive their providers to be doing their jobs well. Limitations of money (as it affects hiring of more staff and getting, as well as giving, training) appear to bear on the ratings "good" and "fair."

Table E25. Effectiveness of Regional Providers: RO Respondents

Rating	Frequency of Response
Excellent	4
Very Good	7
Good	11
Fair	4
Poor	--

(n=64, many of whom were not asked)

Inquiry was also made of Regional Office staff regarding the effectiveness of T/TA service delivered to each of the four identified target groups. The only group for which more than half the respondents rated T/TA effectiveness highly ("excellent" and "very good") was professionals (53.0%). Then, in order, were paraprofessionals (37.0%), parents (36.0%), and finally, support staff (17.0%). Support staff and parents received the largest percentages of low ("fair" and "poor") effectiveness ratings (43.0% and 28.0% respectively). These findings

suggest the following conclusions. One, there probably exists greater focus on T/TA to professionals than to any other group, since they are critical to the programs' maintenance. Two, the quality of the T/TA to professionals is probably better overall than that given to the other groups. In Section E1, we presented data relating to key elements of T/TA presentation and discovered that more local program personnel gave lower ratings than all provider respondents to presentation

Table E26. Effectiveness of T/TA to Target Groups: RO Respondents (n=64)

Ratings	Percent of RO Respondents Rating T/TA Effectiveness to Each Group			
	Professionals	Para-Professionals	Support Staff	Parents
Excellent	4.0	3.0	5.0	8.0
Very Good	49.0	34.0	12.0	28.0
Good	38.0	51.0	40.0	36.0
Fair	9.0	12.0	29.0	28.0
Poor	0.0	0.0	14.0	0.0
Total	100.0	100.0	100.0	100.0

of subject matter at appropriate level, ability to meet participants' needs and sensitivity to needs of poor. These areas are critical to effective T/TA. All groups except professionals are less highly trained, and providers generally appear to have more difficulty in relating the T/TA well to these groups.

Based on the aggregated data of Regional Office Head Start personnel, the training offered by T/TA providers during the past year was judged to have "Quite a Bit" of impact on improving local programs. On a scale of A Great Deal/Quite a Bit/Some/Very Little/None, a few respondents did see only "Some" impact, and a few saw "A Great Deal" of impact but the majority judged it to be "Quite a Bit."

The same scale was used by Regional Office personnel concerning the impact of the technical assistance offered by T/TA providers within the past year. Most judged the technical assistance to have "Quite a Bit" of influence on improving local programs. However, compared to the judgments of the impact of training, the judgment of the influence of technical assistance showed a slightly larger number of respondents who saw it was having only "Some" impact, and a slightly smaller number of respondents judging it to have "A Great Deal" of impact.

RO personnel were asked to rate the T/TA program in regard to meeting the needs of local Head Start units using the following characteristics: complete (adequate in covering the actual needs), practical (useful in assisting their activities), information (clear in educating the participants), timely (punctual in response to the actual needs). Using a scale of 4/3/2/1 with "4" being the highest rating, the data indicates that the general reponse for each of the above characteristics was "3," which can be interpreted as a fairly good rating.

b) Individualized analysis of each of seven case study regions

Presented in this section is an analysis of the collective responses of the persons interviewed in each "case study" Regional Office on the topic of T/TA effects. (See Chapter II for an explanation about the selection of the "case studies.")

NEW YORK (II)

Data in this region was very sketchy on this dimension but there was no indication that the training and technical assistance had little or no impact on improving local programs in Region II.

PHILADELPHIA (III)

Region III respondents indicated they felt the training and technical assistance offered by T/TA providers within the past year had "Quite a Bit" of impact on improving local programs in the region.

On a scale of 4/3/2/1 (with "4" being the best), respondents rated the T/TA as "3" in regard to being complete in meeting needs of local Head Start programs. Ratings were slightly higher for informative and practical T/TA and slightly lower for timely T/TA..

ATLANTA (IV)

Staff tends to regard the impact and influence of the total T/TA services in Region IV rendered as being "A Great Deal" or "Quite a Bit" (on a scale of A Great Deal/Quite a Bit/Some/Very Little/None). T/TA services were regarded by regional staff to be complete, moderately practical, very informative, and moderately timely.

CHICAGO (V)

Scant data was given regarding the impact of T/TA on improving local programs in Region V. One respondent rated the training as having "Quite a Bit" of influence, and the technical assistance as having "Some" impact on local programs.

On a scale of 4/3/2/1 with "4" being the best rating, one out of four respondents in Region V rated the T/TA as "2" in regard to how complete it was in meeting the needs of the local Head Start program, "3" in being practical, and as "2" is being informative and timely.

DALLAS (VI)

A difference of opinion is evident between the respondents who answered these questions in Region VI. One saw both the training and technical assistance as having "A Great Deal" of influence on improving local programs, while another respondent judged it to have only "Some" impact on local programs.

Conflicting opinions are evident concerning how practical, informative, and timely the T/TA program was in regard to meeting local program needs. One respondent rated the T/TA "4" (the best) in all these categories, while another respondent gave them only "2" ratings. In regard to being complete, the T/TA provided was generally given a 2 or 3 rating for meeting local program needs.

SEATTLE (X)

Generally respondents in Region X saw the training offered by providers as having "Quite a Bit" of impact on improving local programs, although two respondents felt it had only "Some" influence.

The same ratings were given by Region X respondents for the influences of T/TA offered by providers on improving local programs. Most said it helped "Quite a Bit," with a couple feeling it only had "Some" impact.

On a scale of 4/3/2/1 with "4" being the highest rating, the T/TA program in Region X was given a "3" in terms of completely meeting the needs of local Head Start units. A "3" rating was given for its practicality as well as its informativeness, but a lower rating of "2" was given by most respondents as regards T/TA timeliness in meeting local program needs.

INDIAN AND MIGRANT PROGRAM DIVISION (IMPD)

A difference of opinion is evident in the data from IMPD as to how much impact the T/TA provided had on local programs. Most saw it as having only "Some" influence, while two respondents judged it to have "A Great Deal" of impact on local program units.

IMPD respondents uniformly rated the T/TA programs as "3" (on a scale of 4/3/2/1 with "4" being best) in regard to being complete, practical, informative, and timely in meeting local program needs.

2. Regional Provider Responses

Presented in this section is an analysis of the responses received from the 77 regional providers interviewed (group two) on the subject of quality of T/TA. None of the RTO/STO network (group one) providers were interviewed on this topic. Regional variations in these data will be highlighted as appropriate.

As with other groups, regional providers were queried through a series of questions designed to shed some light on the T/TA provided via their organizations. The first question posited in this series was, "How much impact has the training and technical assistance your organization has provided in the past year had on improving the programs you serve? Would you say a great deal, quite a bit, some, a little, or none?" The results are exhibited on the next page in Table E27:

Table E27. Extent of Impact of Regional Provider T/TA on Programs Served (n=77)

Responses	Percent
A Great Deal	39.0
Quite a Bit	42.9
Some	10.4
A Little	1.3
None	-
Don't Know	5.2
Not Applicable	1.3

Note: Compare this table with E19 on National Providers.

The responses in Table E27 indicate that a majority of regional providers felt the impact of T/TA on the programs they served was "a great deal" or "quite a bit" (81.9%). This figure contrasts vividly to the 47.1% of national providers making the same responses.

Using that combined figure of 81.9% positive responses as the "norm" against which to check each region's provider answers, we find that three were higher: Regions II (New York) and XI (IMPD), each 100.0%, and Region III (Philadelphia), 92.9%. Two regions were lower: Regions IV (Atlanta), 61.1%, and V (Chicago), 62.5%.

After the question on T/TA impact, providers next responded to questions about the effects of T/TA they had provided in regard to meeting the needs of the local Head Start program, the staff, and the parents. For each of these, they were to rate the T/TA in terms of its being complete, practical, informative, and timely on a scale of 4,3,2, and 1, with 4 equalling the best and 1 the worst. Their responses on these key characteristics are presented in Table E28. (See the explanation about definitions of the terms immediately prior to Table E20 for a reminder, if necessary).

Table E28. Ratings by Regional Providers on Key Characteristics of Their T/TA in Regard to Meeting the Needs of the Local Head Start Program, Staff, and Parents (n=77)

Characteristics	Rating Scale	Percent of Regional Providers on Each Point of Rating Scale for Each Recipient		
		Program	Staff	Parents
Complete	4	22.1	22.1	18.2
	3	61.0	55.8	28.6
	2	9.1	13.0	28.6
	1	2.6	2.6	5.2
	Don't Know	2.6	2.6	7.8
	Not Applicable	2.6	3.9	11.7
Practical	4	61.0	51.9	37.7
	3	29.9	37.7	29.9
	2	5.2	2.6	10.4
	1	1.3	2.6	3.9
	Don't Know	1.3	2.6	7.8
	Not Applicable	1.3	2.6	10.4
Informative	4	64.9	59.7	45.5
	3	31.2	29.9	27.3
	2	1.3	3.9	6.5
	1	--	1.3	2.6
	Don't Know	1.3	2.6	7.8
	Not Applicable	1.3	2.6	10.4
Timely	4	46.8	40.3	31.2
	3	37.7	44.2	33.8
	2	13.0	9.1	13.0
	1	--	1.3	3.9
	Don't Know	1.3	2.6	7.8
	Not Applicable	1.3	2.6	10.4

NOTE: Compare this Table with Table E20 on National Providers.

Looking at the highest ratings, "4" and "3", for each characteristic across each entity (program, staff, parents), it is apparent that, in every instance, a majority of providers are represented. However, note that for complete T/TA, the percentage rating each as "4" declined considerably compared to practical informative, and timely T/TA across all three columns. Both complete and timely T/TA have a greater proportion of lower ratings, "2" and "1", than do practical and informative T/TA.

Now, of the three groups about whose needs we asked, parents show quite a difference. The percentages of those providers rating each characteristic "4" or "3" dropped compared to program and staff. The range of differential was from approximately 20-35%. The greatest difference appeared on complete T/TA.

These findings parallel those from national providers. Complete and timely T/TA manifest lower percentages of "4" or "3" ratings and higher percentages of "2" or "1" ratings across all three groups (program, staff, and parents). The parent group has consistently lower percentages of "4" and "3" ratings on all characteristics, especially complete T/TA.

On this subject of key characteristics of T/TA, numerous regional differences surfaced. We will present them first in tabular form and then make appropriate comments following the presentation of these three consecutive tables:

E29 Key Characteristics of T/TA vis-a-vis program needs.
E30 Key Characteristics of T/TA vis-a-vis staff needs
E31 Key Characteristics of T/TA vis-a-vis parent needs

Table E29. Percent of Each Region's Providers Rating Key Characteristics of T/TA in Regard to Meeting Local Program Needs

Characteristic	Rating Scale	Percent of Each Region's Providers at Each Point in Rating Scale: II (n=4)	III (n=14)	IV (n=18)	V (n=8)	VI (n=14)	X (n=9)	XI (n=10)	Norm for Each Rating
Complete	4	50.0	14.3	27.8	12.5	28.6	0.0	30.0	22.1
	3	25.0	57.1	61.1	75.0	57.1	77.8	60.0	61.0
	2	0.0	21.4	5.6	0.0	7.1	11.1	10.0	9.1
	1	0.0	0.0	5.6	12.5	0.0	0.0	0.0	2.6
Practical	4	100.0	57.1	61.1	87.5	78.6	33.3	30.0	61.0
	3	0.0	21.4	38.9	0.0	7.1	66.7	60.0	29.9
	2	0.0	14.3	0.0	0.0	7.1	0.0	10.0	5.2
	1	0.0	0.0	0.0	12.5	0.0	0.0	0.0	1.3
Informative	4	100.0	71.4	66.7	75.0	64.3	33.3	60.0	64.9
	3	0.0	14.3	33.3	25.0	28.6	66.7	40.0	31.2
	2	0.0	7.1	0.0	0.0	0.0	0.0	0.0	1.3
	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Timely	4	75.0	35.7	66.7	50.0	50.0	22.2	30.0	46.8
	3	25.0	57.1	16.7	50.0	35.7	33.3	50.0	37.7
	2	0.0	0.0	16.7	0.0	7.1	44.4	20.0	13.0
	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

*NOTE: When the percentages for one region within one characteristic do not total 100.0%, the remaining percentages occur in either don't know or not applicable, which were not listed.

Table E30. Percent of Each Region's Providers Rating Key Characteristics of T/TA in Regard to Meeting Staff Needs (n=77)

Characteristic	Rating Scale	Percent of Each Region's Providers at Each Point in Rating Scale*							Norm for Each Rating
		II (n=4)	III (n=14)	IV (n=18)	V (n=8)	VI (n=14)	X (n=9)	XI (n=10)	
Complete	4	50.0	21.4	22.2	12.5	28.6	0.0	30.0	22.1
	3	25.0	57.1	61.1	62.5	57.1	55.6	50.0	55.8
	2	0.0	7.1	11.1	12.5	7.1	33.3	20.0	13.0
	1	0.0	0.0	5.6	12.5	0.0	0.0	0.0	2.6
Practical	4	100.0	50.0	44.4	37.5	57.1	44.4	60.0	51.9
	3	0.0	28.6	44.4	50.0	28.6	55.6	40.0	37.7
	2	0.0	7.1	5.6	0.0	0.0	0.0	0.0	2.6
	1	0.0	0.0	0.0	12.5	7.1	0.0	0.0	2.6
Informative	4	100.0	57.1	50.0	62.5	64.3	33.3	80.0	59.7
	3	0.0	21.4	44.4	25.0	21.4	55.6	20.0	29.9
	2	0.0	7.1	0.0	0.0	7.1	11.1	0.0	3.9
	1	0.0	0.0	0.0	12.5	0.0	0.0	0.0	1.3
Timely	4	75.0	28.6	61.1	37.5	35.7	22.2	30.0	40.3
	3	25.0	50.0	16.7	50.0	50.0	55.6	20.0	44.2
	2	0.0	7.1	16.7	0.0	7.1	22.2	0.0	9.1
	1	0.0	0.0	0.0	12.5	0.0	0.0	0.0	1.3

*NOTE: When the percentages for one region within one characteristic do not total 100.0%, the remaining percentages occur in either don't know or not applicable, which were not listed.

Table E31. Percent of Each Region's Providers Rating Key Characteristics of T/TA in Regard to Meeting Parent Needs (n=77)

Characteristic	Rating Scale	Percent of Each Region's Providers at Each Point in Rating Scale*							Norm for Each Rating
		FI (n=4)	III (n=14)	IV (n=18)	V (n=8)	VI (n=14)	X (n=9)	XI (n=10)	
Complete	4	25.0	28.6	5.6	50.0	14.3	0.0	20.0	18.2
	3	50.0	21.4	33.3	0.0	50.0	0.0	40.0	28.6
	2	0.0	21.4	27.8	37.5	32.4	55.6	30.0	28.6
	1	0.0	0.0	11.1	12.5	0.0	11.1	0.0	5.2
Practical	4	50.0	35.7	22.2	50.0	64.3	33.3	20.0	37.7
	3	50.0	14.3	38.9	25.0	14.3	22.2	60.0	29.9
	2	0.0	21.4	5.6	12.5	0.0	22.2	10.0	10.4
	1	0.0	0.0	5.6	12.5	7.1	0.0	0.0	3.9
Informative	4	75.0	50.0	22.2	50.0	57.1	22.2	70.0	45.5
	3	0.0	14.3	33.3	37.5	21.4	44.4	20.0	27.3
	2	0.0	7.1	11.1	0.0	7.1	11.1	0.0	6.5
	1	0.0	0.0	5.6	12.5	0.0	0.0	0.0	2.6
Timely	4	75.0	28.6	27.8	50.0	57.1	0.0	0.0	31.2
	3	0.0	28.6	16.7	25.0	28.6	44.4	80.0	33.8
	2	0.0	14.3	16.7	12.5	0.0	33.3	10.0	13.0
	1	0.0	0.0	11.6	12.5	0.0	0.0	0.0	3.9

*NOTE: When the percentages for one region within one characteristic do not total 100.0%, the remaining percentages occur in either don't know or not applicable, which were not listed.

Regional variations among providers can be summarized as follows: (See the three preceding tables, E29, E30, and E31, for regional breakdowns.)

- Region II (New York) providers consistently rated T/TA on all characteristics for each group (program, staff, and parents) very highly, either "4" or "3". Their pattern was to be above the "norm" for the "4" rating, and usually below the "norm" on "3". None ever gave a rating of "2" or "1" on any characteristics.

- Region III (Philadelphia) providers, on timely T/TA in regard to program and staff needs, were lower than the norm on the "4" and higher than the norm on "3", which simply means that fewer providers rated timely T/TA at the highest point of the scale. On complete T/TA to parents, these providers were higher than the "norm" for "4". On nearly all other characteristics for all groups they were at or near the "norm".

- Region IV (Atlanta) providers, on timely T/TA, were higher than the "norm" for "4" in regard to program and staff needs, and tended to rate complete, practical, and informative characteristics in regard to parent T/TA "3" rather than "4".

- Region V (Chicago) providers, on practical T/TA for meeting program and parent needs, were higher than the "norm" for "4", and on complete T/TA and timely T/TA for parent needs, were also higher than the "norm" for "4".

- Region VI (Dallas) providers, on practical T/TA for meeting program needs, were higher than the "norm" for "4", and, on practical, informative and timely T/TA for parents, were also higher than the "norm" for "4".

- Region X (Seattle) providers were almost universally lower than the "norm" for "4" on meeting needs of program, staff, and parents. In no instance did any provider rate complete T/TA as "4", the best. This pattern reveals that usually these providers would pick "3" rather than "4". However, on complete T/TA in regard staff and parent needs, a considerably higher percentage than the "norm" rated it as "2", and on timely T/TA for all groups' needs the percentage of "2" ratings was also above the "norm".

- Region XI (IMPD) providers rated timely T/TA for all groups' needs as "3" to a level much higher than the "norm," and for parents' needs were higher than the "norm" for "3" on complete and practical T/TA. Informative T/TA for parents had a much higher percent than the "norm" for "4." Generally, they tended to perceive meeting parent needs in a more favorable light than most other regions.

Seeking another measure of quality of T/TA, we asked regional providers if T/TA to staff and to parents had led to better services for the children. The majority of providers said "yes" to both items, although a higher percentage gave positive responses in regard to staff T/TA than to parent T/TA. These figures are higher than those

Table E32. Better Services for Children As a Consequence of Regional Provider T/TA to Staff and to Parents (n=77)

Responses	Percent of Providers for Each T/TA Recipient	
	Staff	Parents
Yes	92.2	76.6
No	2.6	2.6
Don't Know	3.9	10.4
Not Applicable	1.3	10.4

Note: Compare this Table with E21 on National Providers

given by national providers (92.2% vs. 82.4% and 76.6% vs. 41.2%).

No regional variations occurred for staff T/TA, but there were some for parent T/TA. Comparing each region's provider responses to the "norm" of 76.6% saying "yes," Regions II (New York), VI (Dallas), and XI (IMPD) providers were higher (100.0%, 92.9%, and 100.0% respectively), while Region IV (Atlanta) providers were lower (55.6%).

With those providers who said "yes," our interviewer asked to what extent, according to the scale appearing below, did staff and parent T/TA lead to better services for the children.

Table E33. Extent of Better Services to Children Resulting from Staff and Parent T/TA Offered by Regional Providers (n=77)

Responses	Percent of Providers for Each T/TA Recipient	
	Staff*	Parent*
A Great Deal	51.9	20.8
Quite a Bit	33.8	39.0
Some	3.9	15.6
A Little	-	-
None	-	-
Dont'know/Not Applicable	10.4	24.7

*For staff T/TA, 2 respondents who said yes were not able to judge the extent of better services, so they appear in the don't know/not applicable percentage. For parent T/TA, 1 respondent was treated the same way.

It can be seen that, for staff T/TA, half of the providers responded "a great deal", while only one-fifth gave that answer in regard to parent T/TA. The percentage saying "some" was higher for parent T/TA (15.6%) than for staff T/TA (3.9%).

These findings reveal higher percentages for the responses "a great deal" and "quite a bit" than for those of national providers (see Table E23). However, more national providers than regional said extent of better services for children resulting from parent T/TA was only "some" (20.6% vs. 15.6%).

One is always mindful of the vested interest that providers have in expressing positive results of T/TA they provide, and,

while this factor cannot be discounted, the variation's that occur in relation to this particular perception of extent of better services for children between staff and parent T/TA (as well as other questions) indicate the sincerity and honesty with which most of these providers attempted to approach the interview for this study.

On a region-by-region basis, the following differences have been noted:

- Region II (New York) providers were above the "norm" on "a great deal" (100.0% vs. 51.9%) for staff T/TA, and on "a great deal" (50.0% vs. 20.8%) and "quite a bit" (50.0% vs. 39.0%), for parent T/TA.

- Region III (Philadelphia) providers were lower than the "norm" for "a great deal" on both staff T/TA (21.4% vs. 51.9%) and parent T/TA (7.1% vs. 20.8%), and higher on "quite a bit" for staff T/TA (64.3% vs. 33.8%). Most providers rated both staff and parent T/TA extent of better services as "quite a bit".

- Region IV (Atlanta) providers were below the "norm" on "quite a bit" (27.8% vs. 39.0%), for parent T/TA.

- Region V (Chicago) providers below the "norm" on "quite a bit" for both staff T/TA (12.5% vs. 33.8%) and parent T/TA (25.0% vs. 39.0%), and higher on "some" for both staff T/TA (25.0% vs. 3.9%) and parent T/TA (37.5% vs. 15.6%) which simply says that, for staff T/TA (except for a "a great deal") more providers rated extent of better services "some," and, for parent T/TA, more providers said "some" extent of better services than said either "a great deal" or "quite a bit.".

- Region VI (Dallas) providers were, for staff T/TA, higher than the "norm" on "a great deal" (71.4% vs. 51.9%) and lower than the "norm" for "quite a bit" (14.3% vs. 33.8%). For parent T/TA they were higher than the norm on "quite a bit" (57.1% vs. 39.0%) and lower than the norm on "some" (7.1% vs., 15.6%). This distribution indicates that on staff T/TA, more providers rated extent of better services "a great deal," and, on parent T/TA, more rated it "quite a bit."

- Region X (Seattle) providers were lower than the "norm" on "a great deal" for staff T/TA (33.3% vs. 51.9%), higher on "quite a bit" (55.6% vs. 33.8%), which means that the majority rated staff T/TA "quite a bit," and were lower than the "norm" on "quite a bit" for parent T/TA (22.2% vs. 39.0%). For parent T/TA, of the six providers making ratings, the responses were distributed evenly across all three categories (a great deal, quite a bit, and some).

- Region XI (IMPD) providers were higher than the "norm" on parent T/TA for "a great deal" (40.0% vs. 20.8%) and "quite a bit" (50.0% vs. 39.0%). Only Region II providers rated extent of better services for children resulting from parent T/TA higher than Region XI providers.

Those respondents who said that no better services for children resulted from staff and parent T/TA were asked why not. Of the two respondents who said "no" in regard to staff T/TA, only one could offer a reason, and that person said because there was no centralized state plan. The two respondents who said "no" in regard to parent T/TA said the reasons were, for one person, because too little T/TA was provided, and for the other, because the T/TA was condescending toward the parents, thus it did not generate the desired effect.

c. Local Level Responses

Local level responses on this topic of effects of T/TA, as has been the case with all the preceding topics in this chapter, are discussed first from the viewpoint of directors, staff, parents, and community leaders associated with the 30 Head Start programs sampled and then from that of local level T/TA providers.

1. Local Program Responses

Project staff interviewed a total of 428 directors, staff, and parents and 162 community leaders (see Chpater II for an explanation of the selection process utilized).

To begin the portion of the interview on the effects of T/TA received, the respondents were asked how much impact the T/TA they received in the past year had on improving their program. They were given five possible answers, "a great deal, quite a bit, some, a little, and none." There responses are given in Table E34, following this page.

What this table shows is that six out of ten respondents (59.1%) reported either "a great deal" or "quite a bit" of impact on their local program as a result of T/TA. If the "some" answers are added in, then the percentage jumps to 84.6%. Only 8.4% of the respondents said "a little" or "no" impact was achieved as a result of T/TA.

A look at this data for regional differences shows that--if only the responses "a great deal" and "quite a bit" are binned together within a region--the case studies compare thusly, going from the one with the greatest frequency of these answers to the one with the least.

Region IV Atlanta	78.9% a great deal/quite a bit
Region VI Dallas	67.3% a great deal/quite a bit
Region X Seattle	65.4% a great deal/quite a bit
"NORM"	59.1% a great deal/quite a bit
Region III Philadelphia	57.7% a great deal/quite a bit
Region II New York	50.0% a great deal/quite a bit
Region V Chicago	49.2% a great deal/quite a bit
Region XI IMPD	42.6% a great deal/quite a bit

Some might argue that "some" as a response indicates a positive impact from T/TA as well and should therefore be included in such a region by region comparison. Accordingly, here is how the seven case study regions compare when the "some" responses are added to the "a great deal"

Table E34. Extent of Impact of T/TA on Local Programs on Local Programs (DSP n=428)

TA IMPACT	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION IX	TOTAL
20.	5	17	33	20	23	19	131
A GREAT DEAL	3.8%	13.0%	20.7%	11.5%	13.0%	11.7%	13.7%
	1.2%	4.0%	7.7%	4.7%	5.4%	4.7%	30.5%
21.	16	20	21	16	13	16	122
QUITE A BIT	13.1%	23.5%	17.2%	13.1%	10.7%	14.3%	11.5%
	3.7%	4.7%	4.9%	3.7%	3.0%	3.7%	28.5%
22.	18	17	10	11	6	15	77
SOME	14.7%	17.6%	6.3%	17.4%	7.5%	13.8%	17.9%
	4.2%	4.0%	2.3%	2.6%	1.4%	3.5%	18.0%
23.	3	7	2	0	3	1	0
A LITTLE	2.5%	10.3%	3.4%	0.0%	2.5%	1.6%	0.0%
	0.7%	1.6%	0.5%	0.0%	0.7%	0.2%	3.5%
24.	0	1	0	0	2	1	4
NONE	0.0%	1.5%	0.0%	0.0%	1.7%	1.6%	3.7%
	0.0%	0.2%	0.0%	0.0%	0.5%	0.2%	0.9%
88.	6	7	3	3	2	1	21
DON'T KNOW	4.9%	10.3%	5.2%	3.5%	3.3%	1.6%	4.9%
	1.4%	1.6%	0.7%	0.7%	0.5%	0.2%	5.7%
99.	1	1	0	0	2	1	5
NOT APPL	0.8%	1.5%	0.0%	0.0%	1.7%	1.6%	0.0%
	0.2%	0.2%	0.0%	0.0%	0.5%	0.2%	1.2%
COLUMN TOTAL	48	68	71	63	52	59	61	428
	11.2%	15.9%	16.6%	14.7%	12.1%	13.8%	14.3%	100.0%

and "quite a bit" ones. Again, they are listed in order of declining frequency of response:

Region IV Atlanta	93.0% a great deal/quite a bit/some
Region X Seattle	92.7% a great deal/quite a bit/some
"NORM"	84.6% a great deal/quite a bit/some
Region II New York	83.3% a great deal/quite a bit/some
Region VI Dallas	82.7% a great deal/quite a bit/some
Region XI IMPD	81.9% a great deal/quite a bit/some
Region III Philadelphia	79.5% a great deal/quite a bit/some
Region V Chicago	79.4% a great deal/quite a bit/some

Atlanta remains at the top of this listing, as it was in the previous one which excluded "some" responses; Seattle moves up from third to second place; New York, from fifth to third; Dallas drops down to fourth as opposed to second in the previous listing; IMPD climbs considerably from the last spot in the previous listing to the fifth one in this; both Philadelphia (fourth to sixth) and Chicago (sixth to last) dropped down in order of ranking from the previous listing to this.

These phenomena make it difficult to draw any solid conclusions, except that it is obvious directors, staff, and parents interviewed in Region IV Atlanta consistently thought their T/TA was having greater impact than those in any of the other case studies.

The community leaders were also asked how much impact the T/TA received had on improving the local Head Start program. Their answers are displayed in Table E35, following this page.

This data shows that, as was the case with directors, staff, and parents, six out of ten respondents (62.9%) reported either "a great deal" or "quite a bit" of impact of the local Head Start as a result of T/TA. If the "some" answers are included, then the percentage jumps to

Table E35. Extent of Impact of T/TA on Local Programs (CL n=162)

	REGION							
IMPACT	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION IX	REGION XI	ROW TOTAL
0.	11	7	11	7	7	8	8	59
	20.8%	13.7	20.8	13.7	13.7	14.5	7.5	100.0
	20.8	13.6	22.7	14.3	13.7	14.5	11.4	
	3.7	2.5	3.7	2.5	2.5	2.9	1.4	
1.	0	0	1	0	0	0	0	1
	0.0	0.0	50.0	0.0	0.0	0.0	0.0	1.4
	0.0	0.0	2.3	0.0	0.0	0.0	0.0	
	0.0	0.0	0.6	0.0	0.0	0.0	0.0	
2.	2	1	1	0	0	0	0	4
	33.3	16.7	16.7	0.0	0.0	0.0	0.0	5.6
	5.0	2.3	2.3	0.0	0.0	0.0	0.0	
	1.1	0.6	0.6	0.0	0.0	0.0	0.0	
3.	0	1	0	0	0	0	0	1
	0.0	100.0	0.0	0.0	0.0	0.0	0.0	1.4
	0.0	2.3	0.0	0.0	0.0	0.0	0.0	
	0.0	0.6	0.0	0.0	0.0	0.0	0.0	
4.	1	1	1	1	0	0	0	4
	25.0	25.0	25.0	25.0	0.0	0.0	0.0	5.6
	2.5	2.3	2.3	2.5	0.0	0.0	0.0	
	0.6	0.6	0.6	0.6	0.0	0.0	0.0	
5.	0	0	0	0	0	0	0	0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
6.	0	0	0	0	0	0	0	0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
7.	0	0	0	0	0	0	0	0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
8.	0	0	0	0	0	0	0	0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
9.	0	0	0	0	0	0	0	0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
10.	0	0	0	0	0	0	0	0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
11.	0	1	0	0	0	0	0	1
	0.0	100.0	0.0	0.0	0.0	0.0	0.0	1.4
	0.0	2.3	0.0	0.0	0.0	0.0	0.0	
	0.0	0.6	0.0	0.0	0.0	0.0	0.0	
12.	1	1	1	1	0	0	0	4
	25.0	25.0	25.0	25.0	0.0	0.0	0.0	5.6
	2.5	2.3	2.3	2.5	0.0	0.0	0.0	
	0.6	0.6	0.6	0.6	0.0	0.0	0.0	
13.	2	2	1	0	0	0	0	5
	40.0	40.0	20.0	0.0	0.0	0.0	0.0	7.0
	5.0	4.6	2.3	0.0	0.0	0.0	0.0	
	1.1	1.1	0.6	0.0	0.0	0.0	0.0	
COLUMN TOTAL	41	43	37	40	27	41	33	242
	16.9	17.8	15.3	16.5	11.2	16.9	13.6	100.0

Note: Compare this Table with Table F34 on directors, staff and parent's responses.

84.8%, almost identical to the 84.6% figure for the directors, staff, and parents. This data therefore tends to show that the perceptions of the community leaders on the overall impact of T/TA across the seven case study regions are remarkably alike to those of the directors, and staff, and parents.

Next, KAI interviewers asked another similar question on T/TA impact so as to get a better fix on the perceptions of the directors, staff, and parents. The question was "overall to what extent have the end results of your efforts to assess needs, plan, and management T/TA improved your program performance?" The focus here is more narrow than the preceding question, in that the answers are supposed to reflect impact of T/TA resulting from local level efforts to assess needs, plan accordingly, and then manage their T/TA. Possible answers included "a great deal, quite a bit, some, a little, and none." Their responses are shown in Table E36, following this page.

The findings that stand out are that again six out of ten respondents (60.3%) reported either "a great deal" or "quite a bit" of effect from T/TA. A total of about eight out of ten (78.1%) said that these had been at a minimum "some" program improvement due to T/TA. Very small percentages of interviewees said either "a little" (4.9%) or "no" (1.9%) improvement resulted from T/TA.

Another finding is that, if the two responses "a great deal" and "quite a bit" are isolated as a means for determining relative program improvement due to T/TA among the case study regions, certain regions seem to have more marked improvement than others, at least in the view of these 428 respondents. The regional variations on these two answers

Table E36. Impact of T/TA Resulting From Needs Assessment Planning, Managing at Local Level (DSP n=428)

	COUNT / ROW PCT / COL PCT / TOT PCT	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION IX	REGION XI	ROW TOTAL
PLANNING		2.1	3.1	4.1	5.1	6.1	10.1	11.1	
	1.	11	20	30	19	16	12	13	111
A GREAT DEAL		9.9	18.0	27.0	17.1	14.4	10.8	11.7	27.1
		22.9	25.3	34.9	22.2	30.8	21.8	21.3	
		2.6	4.7	7.0	4.4	3.7	2.8	3.0	
	2.	15	27	23	13	15	23	18	142
QUITE A BIT		10.6	19.0	16.2	9.2	10.6	16.2	12.7	33.2
		31.3	34.2	26.4	15.3	28.8	41.8	29.5	
		3.5	6.3	5.4	3.0	3.5	5.4	4.2	
	3.	10	14	9	16	7	11	13	80
SOME		13.2	19.4	9.0	21.1	9.4	14.5	17.1	17.8
		20.8	17.7	10.3	29.6	13.5	20.0	21.3	
		2.3	3.3	1.6	3.8	1.6	2.6	3.0	
	4.	3	2	1	1	0	2	0	21
A LITTLE		14.3	9.5	4.8	4.8	0.0	9.5	0.0	4.9
		6.3	2.5	1.1	1.9	0.0	3.6	0.0	
		0.7	0.5	0.2	0.2	0.0	0.5	0.0	
	5.	0	0	0	0	0	0	0	8
NONE		0.0	25.0	0.0	0.0	0.0	0.0	0.0	1.9
		0.0	0.6	0.0	0.0	0.0	0.0	0.0	
		0.0	0.2	0.0	0.0	0.0	0.0	0.0	
	8.	1	0	2	0	0	0	0	12
DON'T KNOW		8.3	0.0	16.7	0.0	0.0	0.0	0.0	2.8
		2.1	0.0	2.2	0.0	0.0	0.0	0.0	
		0.2	0.0	0.5	0.0	0.0	0.0	0.0	
	9.	8	7	3	3	4	0	2	29
NOT APPL		27.6	24.1	10.3	10.3	13.8	0.0	6.9	6.8
		19.0	8.9	3.3	5.6	7.4	0.0	4.3	
		1.9	1.6	0.7	0.7	0.9	0.0	0.5	
COLUMN TOTAL		48	79	86	72	54	48	46	433
		11.3	18.6	20.2	16.9	12.7	11.3	10.8	100.0

look like this, going from the region with the greatest percentage of high impact answers to the one with the least:

Region IV Atlanta	77.5% a great deal/quite a bit
Region X Seattle	61.8% a great deal/quite a bit
"NORM"	60.3% a great deal/quite a bit
Region III Philadelphia	60.2% a great deal/quite a bit
Region VI Dallas	59.6% a great deal/quite a bit
Region II New York	54.2% a great deal/quite a bit
Region V Chicago	53.9% a great deal/quite a bit
Region XI IMPD	50.8% a great deal/quite a bit

Some might object that "some" as a response should also be looked at when looking for regional variations. If these answers are added to those of "a great deal" and "quite a bit" then the regional variations are as follows, again from the region with the highest frequency of these three responses to that with the lowest:

Region IV Atlanta	84.5% a great deal/quite a bit/some
Region X Seattle	81.8% a great deal/quite a bit/some
Region V Chicago	79.3% a great deal/quite a bit/some
"NORM"	78.1% a great deal/quite a bit/some
Region III Philadelphia	78.1% a great deal/quite a bit/some
Region II New York	75.0% a great deal/quite a bit/some
Region VI Dallas	73.1% a great deal/quite a bit/some
Region XI IMPD	72.1% a great deal/quite a bit/some

The change in this listing from the previous is non-existent in the cases of Atlanta and Seattle (first and second places respectively both times), New York (fifth both times), and IMPD (last both times); negligible in the case of Philadelphia (fourth one time, third the next); and rather major in the cases of Chicago (third place the first time, next to last the other time) and Dallas (sixth place vs. fourth place).

What should be noted--considering again the global view instead of the regional differences--is that once more Atlanta respondents consistently reported more frequently than those in the other six case study regions higher percentages of greater effect or program improvement as a result of their T/TA activities. Conversely, IMPD respondents regularly gave the least percentages of "a great deal, quite a bit, or some" answers to the query about how much effect their T/TA received actually had.

Then, given these findings, we proceeded to run a bivariate analysis of the results from the directors, staff, and parents on the extent of need for improvement in T/TA needs assessing and planning processes with their ratings on overall impact of T/TA (Table E34). Some significant results appeared. They are displayed here in Table E37, following this page.

Among those respondents who indicated highest T/TA impact ("a great deal"), the largest percentage occurs for those who said "a great deal" of improvement is required in their planning processes. The next largest percentage appears for those who said only "a little/none" improvement required, followed by those who indicated "quite a bit." This distribution suggests that T/TA is perceived to have the greatest impact among those who recognize the most need for substantive improvements in the T/TA needs assessment and planning processes.

As the extent of T/TA impact and need for improvement in T/TA planning declines, the percentage of respondents increases. Thus, of those who answered that T/TA impact was "a little/none," the highest percentage occurs among those indicating need for improvement as "a little/none."

There is evidence that if a person gave one response on one question, he/she tended to give the same response to the other question. The highest percentage of respondents in each row and column is found where the same categories cross, e.g., "a great deal," 58.6%; "quite a bit," 42.1%; "some," 44.6%; and "a little/none," 35.7%.

Table E37. Cross Tabulation of Impact of T/TA With Extent of Need for Improvement in T/TA Needs Assessing and Planning Process

PLANEFFT	TTALEFCT A GREAT DEAL	QUITE A BIT	SOME	A LITTLE-NONE	ROW TOTAL
	20.0	21.1	22.1	23.1	
20. A GREAT DEAL	68	27	16	3	116
	58.6	23.3	13.8	2.6	32.4
	58.6	25.0	17.3	10.0	
	19.0	7.5	4.5	0.8	
21. QUITE A BIT	32	59	46	3	140
	22.9	42.1	32.9	2.1	39.1
	27.6	54.6	44.2	10.0	
	8.9	16.5	12.8	0.8	
22. SOME	7	20	33	14	74
	9.5	27.0	44.6	18.9	20.7
	6.0	18.5	31.7	46.7	
	2.0	5.6	9.2	3.9	
23. A LITTLE-NONE	9	2	7	10	28
	32.1	7.1	25.0	35.7	7.8
	7.8	1.9	6.7	33.3	
	2.5	0.6	2.0	2.8	
COLUMN TOTAL	116	108	104	30	358
	32.4	30.2	29.1	8.4	100.0

Next, in order to get further precision of perception by these directors, staff, and parents in terms of impact due to T/TA, several further questions were asked. Each interviewee was queried as to how well the T/TA received by them in the past year met the needs of the program as a whole, and then the needs of the staff and percents in particular. They were asked to answer in terms of four key characteristics--completeness, practicability, informativeness and timeliness of the T/TA received. They were requested to answer 4, 3, 2, or 1, with 4 being the best and 1 the worst answer. Their responses are shown in Table E38:

Table E38: Ratings by Directors, Staff, Parents on Key Characteristics of their T/TA in Regard to Meeting the Needs of the Local Program, Staff, and Parents (n=428)

Characteristics	Rating Scale	Percent of Rating Scale for Each Recipient		
		Program	Staff	Parents
Complete	4	24.5	25.7	24.5
	3	43.0	39.7	33.2
	2	20.1	15.7	19.9
	1	4.4	4.2	11.7
Practical	4	35.0	26.9	28.7
	3	40.0	42.3	32.7
	2	15.4	12.1	17.5
	1	3.5	4.0	10.5
Informative	4	40.9	37.1	35.3
	3	37.1	32.5	30.6
	2	10.5	12.6	14.7
	1	4.7	2.8	8.6
Timely	4	28.7	22.9	24.3
	3	32.9	36.0	33.2
	2	22.0	18.7	19.4
	1	8.6	6.1	11.2

It appears that if an individual respondent answered one way about the completeness of T/TA received meeting the needs of the entire program, that same respondent tended to give the same answer to the sister questions on meeting the needs of staff and parents in particular.

It also appears that this group of 428 respondents tended to think the T/TA received was more informative when it was received than timely in its reception. Sixty-two percent (61.6%) answered either "3" or "4" (the best) on how timely their T/TA was, but 78.0% answered "3" or "4" on how informative their T/TA was in terms of meeting the needs of their program. The answers on how practical the T/TA received was also tended be favorable, with 75% responding either "3" or "4" on a scale of 1, 2, 3, or 4 (best).

These same questions on the key characteristics of completeness, practicality, informativeness and timeliness of T/TA were also put to the 162 community leaders who were interviewed. Their answers can be seen here in Table E39, following this page.

The same comments made about the directors, staff, and parents' responses, i.e., that if they answered one way about the completeness of T/TA received meeting the needs of the entire program then they tended to give the same response to the sister questions regarding the meeting of needs of staff and parents, can also be made here about the community leaders.

The community leaders seemed to give their highest ratings for T/TA informativeness. In this too they paralleled the directors, staff, and parents' responses. They seem to think however, that T/TA received is timely more than did the directors, staff, and parents. Three-fourths of the leaders (74.1%) answered "3" or "4" vs. six-tenths (61.6%) of the directors, staff, or parents.

Table E39: Ratings by Community Leaders on Key Characteristics of T/TA in Regard to Meeting the Needs of the Local Program, Staff, and Parents (n=162) :

Characterists	Rating Scale	Percent of Rating Scale for Each Recipient		
		Program	Staff	Parents
Complete	4	19.9	23.3	22.5
	3	50.3	43.3	36.4
	2	19.9	15.3	17.2
	1	2.0	0.7	4.6
Practical	4	36.4	36.0	26.5
	3	46.4	39.3	39.7
	2	8.6	9.3	13.9
	1	1.3	0.7	2.6
Informative	4	41.1	38.7	32.5
	3	43.0	40.0	37.7
	2	7.9	4.7	9.9
	1	0.0	0.7	2.6
Timely	4	37.7	33.3	35.1
	3	36.4	31.3	27.2
	2	12.6	13.3	12.6
	1	4.0	2.7	6.0

Note: Compare this Table with E38 on Directors, Staff, and Parents

A cross tabulation was then run of the ratings of directors, staff, and parents on key characteristics of T/TA with regard to meeting the needs of local programs (see Table E38) with their responses on the extent of impact of T/TA (see Table E34). This bivariate analysis is displayed here in Table E40:

Table E40: Cross-Tabulation of Key Characteristics as Regards Meeting Program Needs with Extent of T/TA Impact on Local Program (DSP)

Key Characteristics of T/TA as Regards Meeting Program Needs	Rating Scale	Percent Indicating Extent of T/TA Impact at Each Point in Rating Scale for Each Characteristic: A Grt. Deal	Quite a Bit	Some	A Little/ None	Total Percent at Each Point in Rating Scale
						(n=382)
Complete	4	60.4	26.7	11.9	1.0	26.4
	3	28.3	42.2	23.3	6.1	47.1
	2/1	8.9	16.8	51.5	22.8	26.4
						(n=388)
Practical	4	48.3	33.6	14.7	3.5	36.9
	3	24.2	38.8	30.9	6.1	42.5
	2/1	20.0	10.0	45.0	25.0	20.6
						(n=385)
Informative	4	45.2	34.5	16.7	3.6	43.6
	3	27.5	34.0	34.6	3.9	39.7
	2/1	10.9	10.9	42.2	35.9	16.6
						(n=383)
Timely	4	48.7	33.6	15.1	2.5	31.1
	3	31.2	36.2	25.4	7.2	36.0
	2/1	16.7	23.8	43.7	15.9	32.9

Note: The percents listed in the right-hand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

Table E41. Cross-Tabulation of Key Characteristics as Regards to Meeting Staff Needs with Extent of T/TA Impact on Local Program (DSP)

Key Characteristics of T/TA as Regards Meeting Staff Needs	Rating Scale	Percent Indicating Extent of T/TA Impact at Each Point in Rating Scale for Each Characteristic				Total Percent at Each Point in Rating Scale
		A Great Deal	Quite A Bit	Some	A Little/ None	
Complete						(n=355)
	4	49.0	37.3	8.8	4.9	28.7
	3	29.0	34.3	33.1	4.6	47.6
	2/1	16.7	16.7	42.9	23.8	23.7
Practical						(n=356)
	4	51.9	33.3	12.0	2.8	30.3
	3	23.3	35.6	35.6	5.6	50.6
	2/1	20.6	16.2	35.0	27.9	19.9
Informative						(n=356)
	4	46.7	30.9	18.4	3.9	42.7
	3	22.5	40.6	30.4	6.5	38.8
	2/1	16.7	12.1	45.5	25.8	18.5
Timely						(n=352)
	4	52.2	31.5	15.2	1.1	26.1
	3	30.5	35.1	28.6	5.8	43.8
	2/1	15.1	25.5	39.6	19.8	30.1

Note: The percents listed in the righthand column are based on varing numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

Table E41, displayed on the previous page, shows the bivariate analysis of the key characteristics and the meeting of staff needs vs the extent of T/TA impact on local programs. Similar patterns are evident in regard to T/TA meeting staff needs and T/TA impact as was the case for T/TA meeting program needs. Among those rating each key characteristic "4", the highest percentage of respondents is found indicating T/TA impact.

Generally, the greatest percentage of those rating each key characteristic as "2" or "1" said the highest percentage of minimal T/TA impact (a little/none). This conclusion applies:

- As the rating for each key characteristic of T/TA in regard to meeting staff needs rises, so too does the percent rating the extent of T/TA impact at the highest level ("a great deal"). The lower the rating of each key characteristic, the greater the percentage indicating extent of T/TA impact at its lowest level ("a little/none").

To complete the possible comparisons with data shown in Table E39, still another follow-up cross tabulation was done, between the ratings of the directors, staff, and parents on key characteristics of T/TA with regard to meeting the needs of parents and their responses on the extent of impact of T/TA (see Table E35). This bivariate analysis is displayed in Table E42, following this page.

Since the same patterns occur here as for T/TA on each key elements in regard to meeting both program and staff needs, we will summarize the findings for all:

- As the rating for each key characteristic rises, so does the percentage rating T/TA impact at the highest level ("a great deal").
- As the rating for each key characteristic declines, the percentage rating T/TA impact at the lowest level ("a little/none") increases.
- For "4" ratings, the highest percentage for T/TA impact occurs in the "a great deal" category; for "3" ratings, in the "a quite a bit" category; for "2/1" ratings, in the "some" category.

Table E42. Cross Tabulation of Key Characteristics as Regards Meeting Parent Needs With Extent of T/TA Impact on Local Program (DSP)

Key Characteristics of T/TA as Regards Meeting Parent Needs	Percent Indicating Extent of T/TA Impact at Each Point in Rating Scale for Each Characteristic					Total Percent at Each Point in Rating Scale
	Rating Scale	A Great Deal	Quite A Bit	Some	A Little/ None	
Complete						(n=362)
	4	50.5	35.1	10.3	4.1	26.8
	3	33.3	41.5	22.2	3.0	37.3
	2/1	18.5	17.7	45.4	18.5	35.9
Practical						(n=363)
	4	52.7	33.9	10.7	2.7	30.9
	3	29.2	41.6	26.3	2.9	37.7
	2/1	16.7	17.5	43.9	21.9	31.4
Informative						(n=364)
	4	48.2	32.6	17.0	2.1	38.7
	3	28.8	44.8	23.2	3.2	34.3
	2/1	15.3	13.3	45.9	25.5	26.9
Timely						(n=360)
	4	53.1	29.6	12.2	5.1	27.2
	3	30.1	39.0	25.0	5.9	37.8
	2/1	17.5	26.2	41.3	15.1	35.0

Note: The percents listed in the righthand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

Then additional following questions on the impact of T/TA were put to the directors, staff, parents, and community leaders namely, did they feel T/TA provided to the staff and parents during the past year led to better services for the children, and if so, to what extent? The answers they gave are exhibited in Tables E43 and E44.

Table E43: Better Services to Head Start Children as a Consequence of T/TA to Staff and to Parents

Response	Staff T/TA		Parent T/TA	
	Percent of Directors, Staff, Parents (n=428)	Percent of Community Leaders (n=162)*	Percent of Directors, Staff, Parents (n=428)	Percent of Community Leaders (n=162)*
Yes	88.1	91.4	74.8	78.1
No	5.4	3.3	11.7	4.0

Table E44. Extent of Better Services to Head Start Children as a Consequence of T/TA to Staff and to Parents

Responses	Staff T/TA		Parent T/TA	
	Percent of Directors, Staff, Parents (n=377)	Percent of Community Leaders (n=136)*	Percent of Directors, Staff, Parents (n=319)	Percent of Community Leaders (n=118)*
A Great Deal	41.9	41.9	38.6	39.8
Quite a Bit	43.5	41.2	34.2	37.3
Some	13.8	14.7	24.5	18.6
A Little	0.8	2.2	2.8	4.2

*The responses from community leaders parallel rather closely those of directors, staff, and parents and hence will not be discussed separately.

This data seems to indicate very high degrees of conviction that T/TA received by the local program staff resulted in better services to the children because nearly nine out of ten respondents (88.1%) answered "yes" to this question. Of those who did (377), 85.4% said the impact was either "a great deal" or "quite a bit."

Three-fourths of the respondents (74.8%) said that T/TA given to parents resulted in better services to the children. Of those who said "yes" (319), 72.8% reported that they thought the impact was either "a great deal" or "quite a bit."

The data seems to lend great credence to the Head Start policy of providing training and technical assistance for its staff and parents so that better services result for the children Head Start serves.

Some variations in this data occur on a region-by-region basis for those answering "yes" to each question. They can be observed here in Table E45.

Table E45. Regional Variations in Regard to Better Services for Children as a Consequence of T/TA to Staff and Parents (DSP n=428)

Rank	Percent of Each Region's Respondents Answering "Yes"			
	Staff T/TA Leading to Better Children's Services		Parent T/TA Leading to Better Children's Services	
1st	VI Dallas	100.0%	II New York	89.6%
2nd	IV Atlanta	97.2%	IV Atlanta	83.1%
3rd	XI IMPD	95.1%	X Seattle	78.2%
	"NORM"	88.1%	----------	
4th	II New York	87.5%	VI Dallas	75.0%
	----------		"NORM"	74.8%
5th	X Seattle	87.3%	III Philadelphia	73.1%
6th	III Philadelphia	79.5%	XI IMPD	65.6%
7th	V Chicago	73.0%	V Chicago	61.9%

The findings about Dallas stands out, of course, in that it is the only region in which all respondents answered "yes" to this question about whether T/TA delivered to their staff resulted in better services for the children. Also noteworthy here is the large number of IMPD interviewees (95.1%) who also answered "yes." This percentage gives IMPD its highest ranking in any of the tables so far displayed in this section on excellence of T/TA.

These data on better services to children as a result of T/TA to staff and parents were then subjected to a cross tabulation with the ratings of the directors, staff, and parents on extent of impact of overall T/TA (see Table E34). The results are displayed here in Table E46:

Table E46. Cross Tabulation of Staff and Parent T/TA Leading to Better Children's Services and Extent of Impact From T/TA Provided to Local Program (DSP)

T/TA to Each Group Led to Better Children's Services	Percent Indicating Extent of T/TA Impact and Whether T/TA to Each Group Led to Better Children's Services				Total Percent Indicating Whether Staff and Parent T/TA Led to Better Children's Services
	A Great Deal	Quite A Bit	Some	A Little/ None	
Staff T/TA					(n=380)
Yes	34.4	32.7	27.1	5.9	94.2
No	0.0	4.5	36.4	59.1	5.9
Parent T/TA					(n=350)
Yes	35.3	34.7	26.1	4.0	86.6
No	21.3	12.8	29.8	36.2	13.4

Note: The percents listed in the righthand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

While the percentage of respondents who said staff and parent T/TA did not lead to better children's services and who gave impact ratings was relatively small (5.9% and 13.4% respectively), these respondents differ very markedly from those who said T/TA to these groups did lead to better children's services. A comparison of the high categories of extent of T/TA impact ("a great deal" and "quite a bit") shows that, for staff T/TA, those who answered "no" totaled 4.5% and 34.1%, respectively. Among those indicating "some" or "a little/none" impact for staff T/TA, these answering "no" constituted nearly all the respondents; 95.5% compared to the 66.0% of the "yes" respondents. Thus, as extent of impact declines, generally the percentage of respondents indicating T/TA to staff and parents did lead to better children's services also declines, while the percentage of respondents indicating such T/TA did not lead to better children's services increases.

A comparison bivariate analysis was also undertaken cross tabulating these data on better services to children as a result of T/TA to staff and parents with the ratings of the directors, staff, and parents on satisfaction with overall T/TA (see Table E9). The results are shown here in Table E47.

Table E47. Cross Tabulation of Staff and Parent T/TA Leading to Better Children's Services and Satisfaction Level With T/TA Provided to Local Program (DSP)

T/TA to Each Group Led to Better Children's Services	Percent Indicating Level of T/TA Satisfaction and Whether T/TA to Each Group Led to Better Children's Services			Total Percent Indicating Whether Staff and Parent T/TA Led to Better Children's Services
	Very Satisfied	Satisfied	Dissatisfied/ Very Dissatisfied	
Staff T/TA				(n=390)
Yes	35.4	54.2	10.4	94.1
No	0.0	21.7	78.3	5.9
Parent T/TA				(n=359)
Yes	36.8	55.2	8.1	86.4
No	8.2	42.9	49.0	13.6

Note: The percents listed in the righthand column are based on varying numbers of respondents, as indicated. All don't know and not applicable responses have been omitted.

As can be seen in the righthand column, the total percentage of respondents who said that staff and parent T/TA did not lead to better children's services and who gave satisfaction ratings was relatively small (5.9% and 13.6%) respectively). However, the level of overall T/TA satisfaction expressed in these two respondent groups shows abnormal differences compared to those respondents answering "yes," staff and parent T/TA did lead to better children's services. For staff T/TA, over three-quarters of the respondents who answered "no" were "dissatisfied/very dissatisfied" (78.3%), compared to one-tenth of the "yes" respondents (10.4%). For parent T/TA, the number "dissatisfied/very dissatisfied" who said "no" dropped to one-half (48.0%), while the "yes" respondents totaled slightly less than one-tenth (8.1%). The great majority of "yes" respondents to both staff and parent T/TA leading to better children's services gave positive satisfaction ratings. The great majority of "no" respondents to staff T/TA gave negative satisfaction ratings, and nearly a majority gave the same rating for parent T/TA.

Pulling together these findings for staff and parent T/TA across the overall T/TA satisfaction and impact levels results in these conclusions:

- A positive relationship exists between staff T/TA leading to better children's services and 1) high T/TA impact (67.1%) as well as 2) positive satisfaction (89.6%).

- A positive relationship exists also between parent T/TA leading to better children's services and 1) high T/TA impact (70.0%) as well as 2) positive satisfaction (92.0%).

- Among those respondents who indicated staff T/TA did not lead to better children's services, the percentages rise dramatically as the extent of impact and satisfaction ratings decline. There exists a positive relationship between lack of better children's services from staff T/TA and 1) low T/TA impact (95.5%) as well as 2) negative satisfaction (78.3%).

- Among those respondents who indicated parent T/TA did not lead to better children's services, a positive relationship exists between that lack and low T/TA impact (66.0%), but is less positive for negative satisfaction (49.0%).

- Therefore, it appears that among those respondents answering "no," staff T/TA is more critical as regards impact on program than is parent T/TA.

- For both staff and parent T/TA, it is more difficult to "ensure" impact than it is satisfaction.

Lastly, by way of getting still another indication of the impact of T/TA perceived by this category of respondent, each of them was asked whether their own career development has been helped by any of the T/TA they received at their Head Start program. Their answers are displayed here in Table E48, following this page.

These respondents were then asked how much their career development was helped by T/TA they received. Those responses are given here in Table E49, following Table E48.

What these findings indicate is that well over eight out of ten respondents (84.1%) believe T/TA from Head Start is aiding their career development. Of those who answered in the affirmative (360), roughly eight out of ten (79.4%) thought the help from T/TA was either "a great deal" or "quite a bit."

Regional variations in this data that are notable are:

- Region IV Atlanta respondents answered "yes" (T/TA was helpful to their career development) 95.8% of the time, a greater response than any other individual case study or than the "norm" of 84.1% across all seven regions sampled; also Region IV was the only case study in which not a single interviewee said "no" to this question.

- Of Region III Philadelphia persons interviewed, 91.9% said the extent of the help to their career development from T/TA was either "a great deal" or "quite a bit," a larger percentage than any other region or than the "norm" for these answers of 79.4%.

Table E48. Impact of T/TA on Career Development (DSP n=428)

	...	REGION VI	REGION X	REGIONAL	TOTAL
[illegible]	[illegible]	[illegible]	46	[illegible]	[illegible]
	[illegible]	11.4	12.8	14.6	[illegible]
	[illegible]	72.6	[illegible]	[illegible]	
	[illegible]	9.6	14.7	12.1	
[illegible]	[illegible]	3	4	[illegible]	[illegible]
	[illegible]	11.1	14.8	14.8	[illegible]
	[illegible]	5.3	7.3	[illegible]	
	[illegible]	0.7	[illegible]	[illegible]	
[illegible]	[illegible]	1	3	1	7
	[illegible]	14.3	[illegible]	[illegible]	[illegible]
	[illegible]	1.0	5.5	[illegible]	
	[illegible]	0.2	[illegible]	[illegible]	
[illegible]	[illegible]	7	2	4	34
	[illegible]	20.6	[illegible]	11.8	7.9
	[illegible]	13.5	[illegible]	[illegible]	
	[illegible]	1.6	[illegible]	[illegible]	
TOTAL	[illegible]	52	55	61	428
	[illegible]	12.1	12.9	14.3	[illegible]

Table E49. Extent of Impact of TATA on Career Development (DSP n=428)

[illegible]	REGION II	REGION III	REGION IV	REGION V	REGION VI	REGION X	REGION XI	ROW TOTAL
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	41	[illegible]	[illegible]	[illegible]	[illegible]	11	196
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	40.7	60.1	[illegible]	[illegible]	[illegible]	41.7	[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	16	[illegible]	[illegible]	[illegible]	16	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	25.[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	[illegible]	4.[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	4	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	4.[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	1	[illegible]	[illegible]	[illegible]	[illegible]	1	3	7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	[illegible]	1	1	[illegible]	0	1	3
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	2	[illegible]	[illegible]	2	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7.[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	11.[illegible]	[illegible]	[illegible]	

When the variable indicating whether the respondent's own career development was aided through T/TA is crossed with the overall T/TA impact variable, the following relationships appear:

- Among those who answered "yes" to T/TA aiding personal career development, the highest percentage is found under the highest T/TA impact rating ("a great deal"), and thereafter declines as the impact rating decreases.
- Among those who answered "no," there is some variation in the distribution of responses, but the tendency for the percentage of respondents to increase as the extent of T/TA impact decreases obtains.

Table E50.—Cross Tabulation of T/TA Impact With Career Development

CAREERDEV	T/TEFCT	A GREAT BIT	QUITE A BUNC	A LITTLE SOME	NONE	ROW TOTAL
	COUNT					
	ROW PCT					
	COL PCT					
	TOTAL PCT		21.1	22	23.1	
1. YES		121	113	91	26	351
		34.5	32.2	23.9	7.4	94.1
		96.8	97.4	91.9	78.8	
		32.4	30.3	24.4	7.0	
2. NO		4	3	8	7	22
		18.2	13.6	36.4	31.8	5.9
		3.2	2.6	8.1	21.2	
		1.1	0.8	2.1	1.9	
COLUMN TOTAL		125	116	99	33	373
		33.5	31.1	26.5	8.8	100.0

Those answered "yes" to the question of career development were asked to what extent their development had been helped by the T/TA. Their responses were then crossed with T/TA impact and the following patterns revealed in Table E51.

Table E51. Cross Tabulation of Extent of Career Development and T/TA Impact

	TTAEFFCT				
COUNT / ROW PCT / COL PCT / TOT PCT	A GREAT IDEAL 20.0	QUITE A BIT 21.0	SOME 22.0	A LITTLE-NONE 23.0	ROW TOTAL
CAREREXT					
20. A GREAT DEAL	90	59	32	11	192
	46.9	30.7	16.7	5.7	54.5
	74.4	51.8	34.0	44.0	
	25.6	16.8	9.1	3.1	
21. QUITE A BIT	22	41	32	8	103
	21.4	39.8	31.1	7.8	29.3
	18.2	36.0	34.0	32.0	
	6.3	11.6	9.1	2.3	
22. SOME	7	13	25	6	51
	13.7	25.5	49.0	11.8	14.5
	5.8	11.4	27.2	24.0	
	2.0	3.7	7.1	1.7	
23. A LITTLE-NONE	2	1	3	0	6
	33.3	16.7	50.0	0.0	1.7
	1.7	0.9	3.3	0.0	
	0.6	0.3	0.9	0.0	
COLUMN TOTAL	121	114	92	25	352
	34.4	32.4	26.1	7.1	100.0

Two findings emerge from these data:

- A positive relationship exists between extent of career development and T/TA impact. The higher the extent of career development, the greater the percentages as extent of T/TA impact rises.
- Respondents tended to use the same category of response in both variables, thus, the highest percentages are found in the cell where each like category crosses (e.g., "a great deal," 46.9%; "quite a bit," 39.8%; and "some," 49.0%).

2. Local Providers Responses

As with other providers, local providers queried through a series of questions designed to give us some measures of effects through the T/TA provided by their organizations. The first question put to them in this series was, "How much impact has the training and technical assistance your organization has provided in the past year had on improving the programs you serve? Would you say a great deal, quite a bit, some, a little, or none?"

Table E52. Extent of Impact of Local Provider T/TA on Programs Served (n=24)

Responses	Percent
A Great Deal	29.2
Quite a Bit	20.8
Some	29.2
A Little	--
None	--
Don't Know	12.5
Not Applicable	8.3

Note: Compare this Table with Table E19 (National Providers) and Table E27 (Regional Providers).

The distribution of responses is relatively even across the first three responses (a great deal, quite a bit, and some). The percent responding "a great deal" is higher than that for national providers (14.7%) and lower than that for regional providers (39.0%). Looking at the combined percentages of the two highest ratings reveals that local providers' responses totaled 50.0%, a figure comparable to that of national providers, 47.1%, and that both these percentages are significantly lower than that for regional providers, 81.9%. Whether this congruency between local and national providers indicates a more realistic perception of impact than regional providers is not known.

The only regional variations among these local providers are that no providers in Region II (Philadelphia) rated impact as "a great deal," and no providers in Region V (Chicago) said impact was "quite a bit"--it was either "a great deal" or "some."

From the question on impact, we began a series of questions designed to determine how complete, practical, informative, and timely the T/TA given by local providers was in regard to meeting the needs of the local Head Start program, staff, and parents. For each of these key characteristics (complete, practical, informative, and timely) a scale of 4, 3, 2, and 1 was included, and the respondent was to rate each characteristic using this scale, with 4 equalling the best, and 1, the worst. If the interviewee had a question about the definition of one of these words (complete, practical, informative, and timely), the interviewer offered it using only the particular definition given below:

Complete--adequate in covering the actual needs
Practical--useful in assisting their activities
Informative--clear in educating the participants
Timely--punctual in response to the actual needs

Table E53 follows this page.

The common pattern across all these characteristics and groups is that most respondents answered "4" or "3." For practical, informative, and timely T/TA in regard to meeting program and staff needs, the percentage of those saying "4" and "3" hovers around the 80.0% mark but, for complete T/TA in regard to these two groups, the figures declined to the 60.0% level, and a high percentage of "2" ratings occurs. For staff, very few providers rated complete T/TA as "4," and for parents none. The majority of providers rated complete T/TA to parents as "2." All characteristics in regard to meeting parent needs evidence lower percentages of "4" and "3" ratings than do program and staff needs, and it is only on these characteristics for parents

Table E53. Ratings by Local Providers on Key Characteristics of Their T/TA in Regard to Meeting the Needs of the Local Head Start Program, Staff, and Parents (n=24)

Characteristics	Rating Scale	Percent of Local Providers on Each Point of Rating Scale for Each Recipient		
		Program	Staff	Parents
Complete	4	25.0	8.3	--
	3	37.5	54.2	20.8
	2	25.0	29.2	41.7
	1	--	--	8.3
	Don't Know	4.2	--	12.5
	Not Applicable	8.3	8.3	16.7
Practical	4	37.5	33.3	16.7
	3	45.8	50.0	33.3
	2	8.3	8.3	20.8
	1	--	--	4.2
	Don't Know	--	--	8.3
	Not Applicable	8.3	8.3	16.7
Informative	4	25.0	37.5	16.7
	3	54.2	45.8	50.0
	2	8.3	8.3	4.2
	1	--	--	4.2
	Don't Know	4.2	--	8.3
	Not Applicable	8.3	8.3	16.7
Timely	4	41.7	41.7	20.8
	3	37.5	37.5	33.3
	2	12.5	8.3	8.3
	1	--	--	8.3
	Don't Know	--	4.2	12.5
	Not Applicable	8.3	8.3	16.7

Note: Compare this Table with Table E20 (National Providers) and Table E28 (Regional Providers).

that "1" ratings (the worst) appear. Generally, local providers manifest the same type pattern as do the other providers: complete T/TA in regard to meeting needs of all groups is more difficult to effect really well, and T/TA that meets parents' needs enjoys a reduced level of confidence as compared to that for program and staff needs.

Regional variations occurred, and they are simply summarized briefly here.

- Region III (Philadelphia) providers, in regard to meeting needs of the local program, staff, and parents, never rated either complete T/TA or informative T/TA as "4," which made each lower than that norm for every group. They usually rated each "3," which made that percent higher than the "norm." On timely T/TA, the percentage of "4" ratings was higher than the norm for staff and for parents' needs.

- Region IV (Atlanta) providers tended on most characteristics to rate the T/TA as "3" instead of any other rating, in regard to meeting needs of the local program, staff, and parents. There were higher than the "norm" for "4" on complete T/TA for parents needs.

- Region V (Chicago) providers were lower than the norm on "4" and "3" for complete T/TA in regard to program and staff needs. Except for this, they tended also to rate most characteristics as "3" for all groups' needs.

- Region XI (IMPD) providers were higher than the "norm" for "4" on every characteristic in regard to program and staff needs. Most respondents answered "4" for each of these. As regard parent needs, except for complete T/TA on which "3" ratings were higher than the "norm," all other characteristics were lower than the norm for "4" (0.0%).

Still another measure of the effects of T/TA to staff and parents came through questions asking if T/TA to each of these groups led to better services for children. Virtually all local providers said "yes" in regard to staff T/TA, and three-quarters gave positive responses in regard to parent T/TA.

Table E54. Better Services for Children as a Consequency of Local Provider T/TA to Staff and to Parents (n=24)

Responses	Percent of Providers for Each T/TA Recipient	
	Staff	Parents
Yes	91.7	75.0
No	--	--
Don't Know	--	8.3
Not Applicable	8.3	16.7

Note: Compare this Table with Table E21 (National Providers and Table E32 (Regional Providers).

These percentages are higher than those national providers who said "yes" (82.4% and 41.2%) and almost exactly the same as those of regional providers (92.2% and 76.6%). Unlike each of these groups of providers, no local provider responded "no."

No regional variations emerged on staff T/TA, but for parent T/TA, Region IV (Atlanta) providers were higher than the "norm" (88.9% vs. 75.0%).

Those who said "yes" were then asked to specify the extent of these better services to children resulting from staff and parent T/TA. For staff T/TA, most providers indicated "quite a bit" extent of better children's

Table E55. Extent of Better Services to Children Resulting From Staff and Parent T/TA Offered by Local Providers (n=24)

Responses	Percent of Providers for Each T/TA Recipient	
	Staff	Parent
A Great Deal	20.8	12.5
Quite a Bit	45.8	25.0
Some	25.0	33.3
A Little	--	4.2
None	--	--
Don't Know/Not Applicable	8.3	25.0

Note: Compare this Table to Table E22 (National Providers) and Table E33 (Regional Providers).

services, while one-quarter indicated only "some." The percentages for parent T/TA are lower for the higher ratings--only one-quarter for "quite a bit"--but one-third for "some" extent of better services to children.

A comparison of these findings with the other providers shows that, combining "a great deal" and "quite a bit" responses for staff T/TA, local providers totaled 66.6%; regional providers, 85.7%; and national providers, 52.9%. For parent T/TA, the percentages were local, 37.5%; regional, 59.8%; and national, 14.7%. Thus, in both cases, more regional providers perceived the extent of better services to be greater than did local and national providers. National providers tended to be more pessimistic, especially in regard to parent T/TA. The fact that both local and national perceptions of extent of better children's services tended to be lower seems to decrease the plausibility that less familiarity on the part of national providers with local

programs accounts for the lower percentages. Our sample size is small for local and national providers, granted, but the findings suggest that this may be an example of inflated responses from regional providers, given their vested interest in making positive responses.

Some differences among the regions' local providers exist. They are summarized as follows:

- Region III (Philadelphia) providers did not give extent of better services resulting from staff T/TA, a valuation of "a great deal" (0.0% vs. the "norm" of 20.8%); rather most said "quite a bit" (66.7% vs. 45.8%). But for parent T/TA, "a great deal" was higher than the "norm" (33.3% vs. 12.5%) and "quite a bit" was lower (0.0% vs. 25.0%).

- Region IV (Atlanta) providers were at or near the "norm" for each valuation under staff T/TA, but for parent T/TA were under the "norm" for "a great deal" (0.0% vs. 12.5%), and higher than the "norm" for "some" (44.4% vs. 33.3%), which simply means the half the providers making valuations said "some."

- Region V (Chicago) providers were at or near the "norm" for each valuation under staff T/TA, but for parent T/TA were lower than the "norm" on Some" (22.2% vw. 33.3%). Their responses were evenly distributed across the valuations "a great deal," "quite a bit," and "some" (three said don't know or not applicable).

- Region XI (IMPD) providers were higher than the "norm" for "a great deal" in regard to staff T/TA resulting in better children's services (66.7% vs, 20.8%). No providers rated it "some." For parent T/TA, none rated extent of better services as "a great deal" (0.0% vs. 12.5%).

Summation of E2 Findings: Effects of T/TA

The question at issue here was "After Head Start has managed T/TA, and the providers have delivered it, what effects does it bring about?"

In general an easy majority of both regional office staff interviewed and local program respondents (directors, staff, and community leaders) reported that they perceived the overall impact of Head Start T/TA to be "quite a bit" or "a great deal", on a scale "a great deal", "quite a bit", "some", a "little", or "none". (see tables E34 and E35). Considering local program responses alone, if "some" impact answers are included, then 85% of these respondents reported the T/TA impact was moderate to high, i.e., a great deal, quite a bit, or some. Either way these answers are grouped, it seems that the T/TA being provided to Head Start is having a substantive impact, according to those people who comprised our sample.

A related question on impact was also asked of the local program respondents, namely "to what extent have the end results of your efforts to assess needs, plan and manage T/TA improved your program performance?" Using the same five point scale, six out of ten respondents (see table E36) reported "a great deal" or "quite a bit" of impact - which percentage parallels and confirms the earlier finding on overall impact of T/TA.

The providers sampled were likewise queried about their perception on how much overall impact the T/TA they delivered had on Head Start consumers. By lumping all "a great deal", "quite a bit", and "some" responses together for consideration, the following pattern emerges among providers: 76.5% of the national, 92.3% of the regional and 79.2% of the local ones gave such favorables ratings regarding overall impact of T/TA. Clearly, the regional providers believe more impact results from T/TA they deliver than either the national or local ones report resulting from their T/TA (see tables E19, E27, and E52). However, all three levels of providers perceive the impact of their T/TA to be quite high; this collective perception also parallels that of the local program respondents generally. We think that it is important here to

reiterate a conclusion mentioned in the Summation of M5 Findings, namely that "regional Officers - through somewhat regular reporting at least - are controlling their providers quite effectively and seemingly more stringently than the National Office controls the national providers." The conclusion of this section that regional provider T/TA seems to be having the best effect of all levels of T/TA seems to be very compatible with the conclusion of that earlier section that regional providers are the best controlled. In other words, in the regions sample, good control of T/TA providers by such mechanisms as reporting is apparently paying off well in terms of high impact when the T/TA is finally delivered.

This control mechanism and the matching of expertise to needs were factors affecting regional offices responses about the effectiveness of both national and regional providers. Overall, national providers were judged less effective than regional, although two groups, the United States Public Health Service and American Academy of Pediatrics, received a substantial proportion of high ratings. Regional providers were almost unanimously rated "good", "very good", and "excellent".

Questions were also asked both the local program respondents (i.e., the directors, staff, parents, and community leaders) and all the T/TA providers interviewed about certain key characteristics of T/TA. This was done in order to get additional insight into the impact of T/TA. The key characteristics probed were completeness, practicality, informativeness, and timeliness. The two key characteristics that stood out as strongest considering the answers of all these respondents were practicality and informativeness. Conversely, they reported less favorable opinions generally for the completeness and timeliness of T/TA. The directors, staff and parents were always paralled by the community leaders on answers to these items - still another, albeit indirect, indication of the apparent close relationship between the two groups. The three levels of providers, however, did not at all reflect one another in answering about these key characteristics. The regional providers, following what by now is a familiar pattern, tended to rate their T/TA on all four characteristics much more favorably than either national or local providers rated theirs.

The national providers as a group again scored lower - by quite a margin - than both the regional and local providers interviewed. All of this data can be considered in detail by referring to Tables E20, E28, E38, and E53.

Once more the possibility of "inflation" of answers by respondents should be recalled as a consideration when interpreting these data. Specifically, regional providers obviously have much to gain by inflating their answers on how much impact their T/TA is having. Even if only subconciously, they may be trying to suggest a greater impact than is actually the case. One counter-point to this of course is, why would the regional providers consistently be guilty of this and not the national or local? Possibly they are as well. If so, the phenomenon is one that is occurring at all three levels. This would mean that our data is still quite valid as far as the relative differences among national, regional and local providers.)

Another finding that emerges from these data is that as a rule, T/TA delivered to parents is rated lower in terms of all four key characteristics, i.e., complete, practical, informative, and timely, than T/TA delivered to staff or to the local program considered as a whole. This information relates closely to that revealed in Section D4, T/TA Target Groups, about how parents were regularly perceived as a group that needed more T/TA. (See, for example, Table D48).

Linked to these findings are those from regional office respondents, more of whom judged T/TA effectiveness as "good", "very good", or "excellent" to professionals and paraprofessionals (91.0% and 88.0% respectively) than to parents (72.0%).

A bivariate analysis of overall perceived impact of T/TA (by the directors, staff, and parents) with opinions on how complete, practica, informative and timely T/TA is showed that, as might be expected, the

higher the ratings for the key characteristics of T/TA, the greater the overall impact that T/TA, is perceived as having (see Tables E40, E41, and E42).

Finally, as still another measure of effect of T/TA, the local program respondents and the providers were asked if and to what extent T/TA delivered to staff and parents resulted in better services to the children enrolled in the Head Start programs sampled. Almost all respondents (over 82% and up to 92% of national, regional, and local providers, directors, staff, parents, and community leaders) reported that T/TA to staff resulted in better services to children. Directors, staff, parents and community leaders, and regional providers more frequently answered "to a great extent" (i.e., 85% of the time they thought T/TA given to staff was having "a great deal" or "quite a bit" of effect in terms of better services to children). Fewer respondents (about 75% of regional and local providers, directors, staff, parents, and community leaders vs 41% of the national providers, many of whom indicated the question was not applicable) felt T/TA delivered to parents resulted in better services to Head Start children. Local program respondents most frequently thought T/TA being given to parents was having "a great deal" or "quite a bit" of effect in terms of better services to children (about 75%); however it is difficult to assess provider responses as there were a large number of them reporting "not applicable" to this item.

CHAPTER III

FINDINGS AND CONCLUSIONS

READER'S GUIDE TO TOPICAL SECTIONS

MANAGEMENT OF T/TA

- M1 Head Start Objectives
- M2 Policy and Guidance
- M3 Needs Assessment and Planning
- M4 Selection of Providers
- M5 Control of Providers
- M6 Evaluation of Providers

DELIVERY OF T/TA

- D1 Satisfaction with T/TA Dollars
- D2 T/TA Resources Utilized
- D3 Other Supportive Resources
- D4 Target Groups
- D5 Content Categories
- D6 Special Categories

EXCELLENCE OF T/TA

- E1 Quality of T/TA
- E2 Effects of T/TA

SPECIAL SECTION

- DF Direct Funding of T/TA

Section DF: Are there advantages to directly-funding local programs so that they can purchase their own T/TA?

In this last section of Chapter III we are presenting data related to differences that may be found between those programs which receive money directly from the state training office or the regional office (PA 20 monies) to buy some of their own training and technical assistance and those programs which do not.

KAI staff assumed that variations in T/TA satisfaction and impact, as well as other key variables, could occur between directly-funded and non-directly funded programs. Our sample included some directly-funded programs, which exist in most regions.

Among our case study regions, Region II (New York) has several; Region III (Philadelphia) has directly-funded all programs in the state of West Virginia, as well as numerous other programs scattered across the states in its jurisdiction; Region IV (Atlanta) had, at the time our interviews were conducted, some 3 dozen such programs, but planned in FY 75 to eliminate all such funding directly to these programs; Region V (Chicago) has recently instituted a policy of all programs being directly-funded in some amount, and it is the only region of all the eleven his has this all-encompassing distribution of T/TA money; Region VI (Dallas) also has distributed PA 20 monies to selected programs, but they constitute a minority within the region; Region X (Seattle) funds programs directly in the State of Alaska only; and Region XI (IMPD), through its Offices of Indian Child Services (OICS) and Migrant Educational Development Center (MEDC), channels T/TA money to numerous programs under its management. In our sample, directly-funded programs were selected in these regions:

Region III	2
Region IV	2
Region V	3
Region XI	2
Total	9

In other words, nine of the 30 local programs that constituted the sample were directly funded, slightly less than one-third of the total.

The strength of determining whether differences in fact do exist between these two types of program lies in isolating selected variables and crossing each with the two program types. Therefore, we separated directly-funded programs from those which were not and ran a bivariate analysis on these selected variables. In each of the discussions and tables that follow, the percent of don't know and not applicable responses will be ignored. Overall, T/TA satisfaction did not reveal notable differences between respondents from the two types of programs. About the same proportion of both groups appeared in each category of response (very satisfied to very dissatisfied).

In the matter of overall T/TA impact, a comparison of the two percents in Table DF1 for each program type indicates that a higher percentage of directly-funded program respondents said that the T/TA to their program had "a great deal" and "quite a bit" of impact than did non-directly-funded program respondents (70.4% vs. 53.9%). Conversely, fewer respondents from directly-funded programs said T/TA impact was "a little" or "none" than did those from non-directly funded programs (5.2% vs. 9.9%) At the neutral level of "some", the comparison was 18.5% vs. 28.7%, the lesser percent being from directly-funded programs. So, by a 15% differential, more directly-funded program respondents indicated T/TA impact at the positive end of the rating scale.

See Table DF1 following this page.

Table DF1: Comparison of Respondents in Directly-Funded Programs and Non-Directly-Funded Programs Rating Extent of Perceived Impact of T/TA (n = 428)

DIRFUND	TTAEFCT	20.1 A GREAT IDEAL	21.1 QUITE A BIT	22.1 SOME	23.1 A LITTLE	24.1 NONE	88.1 DON'T KNOW	99.1 NOT APPL	ROW TOTAL
1. YES	COUNT	46	49	25	4	3	8	0	135
	ROW PCT	34.1	36.3	18.5	3.0	2.2	5.9	0.0	31.5
	COL PCT	35.1	40.2	22.9	16.0	27.3	38.1	0.0	
	TOT-PCT	10.7	11.4	5.8	0.9	0.7	1.9	0.0	
2. NO	COUNT	85	73	84	21	8	13	9	293
	ROW PCT	29.0	24.9	28.7	7.2	2.7	4.4	3.1	68.5
	COL PCT	64.9	59.8	77.1	84.0	72.7	61.9	100.0	
	TOT-PCT	19.9	17.1	19.6	4.9	1.9	3.0	2.1	
COLUMN TOTAL		131	122	109	25	11	21	9	428
		30.6	28.5	25.5	5.8	2.6	4.9	2.1	100.0

The next question we chose for a bivarable cross was that asking the respondents to rate key characteristics of T/TA in regard to meeting the needs of the program. Several tables have been collapsed into one for ease of comparison.

Table DF2. Comparison of Respondents in Directly-Funded Programs and Non-Directly-Funded Programs Rating Characteristics of T/TA in Regard to Meeting Needs of the Program

Characteristics of T/TA	Rating Scale	Percent of Respondents at Each Point in Rating Scale (n=135)* Directly-Funded Programs	(n=293)* Non-Directly Funded Programs
Complete	4	25.9	23.9
	3	51.9	38.9
	2	14.1	22.9
	1	3.7	4.8
Practical	4	47.4	29.4
	3	34.1	42.7
	2	10.4	17.7
	1	3.7	3.4
Informative	4	54.1	34.8
	3	28.9	41.0
	2	8.1	11.6
	1	3.0	5.5
Timely	4	37.8	24.6
	3	28.5	20.4
	2	11.9	26.6
	1	5.9	9.9

* Don't know and Not Applicable responses omitted, but percentages based on total number in each type of program.

A review of this table reveals several differences between the two types of programs. For every characteristic more respondents from the directly-funded programs gave the rating "4" than those from non-directly-funded ones and more respondents from the non-directly-funded programs gave the rating "3" than "4". (Recall the 4 equals the best, and 1 equals the worst.) The directly-funded program respondents followed that pattern for complete and timely T/TA (although on timely T/TA the split between "3" and "4" is practically even), but for practical and informative T/TA more respondents rated each "4" than "3".

In addition, a comparison of the totals of "4" and "3" (the positive end of the scale) and of "2" and "1" (the negative end of the scale) for each group on each characteristic shows that a 10% or greater differential occurred on two characteristics. For complete T/TA, 77.8% of the directly-funded program respondents rated it "4" and "3", and 17.8% "2" and "1". The figures for non-directly-funded program respondents were 62.8% and 27.7%. For timely T/TA, 76.3% of respondents from directly-funded programs said "4" and "3" and 17.8% "2" and "1", compared to 55.0% and 36.5% of respondents from non-directly-funded programs. So, for complete and timely T/TA (two characteristics which had lower percentages of "4" and "3" in the aggregated tables for DSP, E35, and for national, regional, and local providers, Tables E21, E25, and E49, respectively) directly-funded program respondents indicated a significantly lower percentage of negative ratings than did non-directly-funded program respondents.

In regard to the question as to whether T/TA to staff led to better services for the children, no appreciable differences occur on this variable. "Yes" responses totalled 90.4% of respondents from directly-funded programs compared to 87.0% from non-directly-funded programs. But when asked to what extent this staff T/TA led to better children's services, there were some variations, as can be noted in Table DF3, following this page.

Table DF3: Comparison of Respondents in Directly-Funded Programs and Non Directly-Funded Programs Rating Extent to Which Staff T/TA led to Better Services for Children

DIRFUND	EXTIMPR: A GREAT DEAL	QUITE A BIT	SOME	A LITTLE	ROW TOTAL
	20.1	21.1	22.1	23.1	
1. YES	57	56	8	1	122
	46.7	45.9	6.6	0.8	32.4
	36.1	34.1	15.4	33.3	
	15.1	14.9	2.1	0.3	
2. NO	101	108	44	2	255
	39.6	42.4	17.3	0.8	67.6
	63.9	65.9	84.6	66.7	
	26.8	28.6	11.7	0.5	
COLUMN TOTAL	158	164	52	3	377
	41.9	43.5	13.8	0.8	100.0

Of the directly-funded program respondents, 92.6% said "a great deal" and "quite a bit", while only 6.6% said "some". These figures compare to 82.0% and 17.3% of non-directly-funded program respondents. So there is a tendency for more of the former group of respondents to perceive greater amount of improvement to children's services resulting from staff T/TA than the latter group. Those respondents who said "no" to the question about staff T/TA leading to better children's services showed no particular differences between the two program types.

In regard to parent T/TA leading to better services for the children and extent of improvement, no appreciable differences existed. But, when those who said no to the question about T/TA to parents leading to better children's services were asked why not, variations appear among the responses. Table DF4 shows that those directly-funded program respondents who said the reason for no better services was because no T/TA or too little was provided totalled 25.0% (out of 12 answering no), while those from the non-directly programs totalled 63.9% (out of the 36 answering no). So parent T/TA apparently is provided more frequently to direct-funded than non-direct funded programs. An interesting reversal comes in the reason

Table DF4: Comparison of Respondents In Directly-Funded Programs and in Non-Directly Funded Programs Reporting Why Parent T/TA Does Not Result in Better Services for Children.

DIRFUND		1.0	2.0	3.0	5.0	88.0	ROW TOTAL
	COUNT						
	ROW PCT	INU TETA	LACK OF	TOO COMP	OTHER	Don't Know	
	COL PCT	PROVIDED	INTEREST	ESCENDA			
	TOT PCT						
1.0 YES		3	4	4	0	1	12
		25.0	33.3	33.3	0.0	8.3	25.0
		11.5	66.7	28.6	0.0	100.0	
		6.3	8.3	8.3	0.0	2.1	
2.0 NO		23	2	10	1	0	36
		63.9	5.6	27.8	2.8	0.0	75.0
		88.5	33.3	71.4	100.0	0.0	
		47.9	4.2	20.8	2.1	0.0	
COLUMN TOTAL		26	6	14	1	1	48
		54.2	12.5	29.2	2.1	2.1	100.0

"lack of interest" on the part of the parents, which 33.3% of directly-funded program respondents answering "no" cited as compared to only 5.6% of the other group.

Finally, we checked to see if satisfaction with nutrition, psychological services, and handicapped services T/TA altered as a function of the type of funding. The assumption behind doing this particular set of bivariates was that directly-funded programs would, if resources were available, be able to fill the T/TA gaps in these areas if they existed. However, in none of these three instances did notable variations appear between the two groups.

To summarize, based on some selected variables, directly-funded program respondents show:

- a higher percentage of perceived positive overall T/TA impact (a great deal, quite a bit) than the other group (70.4% vs. 53.9%);

- a higher percentage of perceived positive ratings (4 and 3) than the other group for complete T/TA (77.8% vs. 62.8%) and timely T/TA (76.3% vs. 55.0%) in regard to meeting the needs of the local Head Start Program, which stands in contrast to all other categories of respondents (aggregated director, staff, parents;

national, regional, and local providers);

- a higher percentage of perceived positive extent of better services for children resulting from staff T/TA (a great deal, quite a bit) than the other group (92.6% vs. 82.0%)

- no differences on overall T/TA satisfaction, nutrition, psychological services, and handicapped services T/TA satisfaction, or extent of better services for children resulting from parent T/TA.

Generally then, while no appreciable differences emerge in regard to the quality of T/TA among the variables we selected to compare directly-funded and non-directly-funded respondents' answers, there are differences in regard to the effects of T/TA. More of the directly-funded group see positive impact than the non-directly-funded group.

It would be worthwhile to explore these findngs in greater detail across numerous other variables in our instrument. The tendencies revealed here favor direct-funding of programs, but, at present, that must be a tentative finding applicable only to effects of T/TA/

Summation of DF Findings: Directly Funded T/TA

Several factors involving direct-funded programs were compared to non-direct funded ones. On the matter of satisfaction with overall T/TA received there seemed to be no notable differences between respondents from the nine direct-funded programs in our sample and those from the other 21 programs. However, on the matter of impact perceived from T/TA, more respondents associated with direct funded programs (70.4%) reported that the impact of T/TA was great than did those associated with non-direct funded programs (53.9%). This of course seems to be the most important place to look for a comparison, i.e., the effect that T/TA is having. The data suggests strongly that a greater effect results from T/TA that is directly purchased by a local program. This funding relates closely to that in E1 showing that, the closer to the local level the source of the T/TA, the greater the chances for satisfaction with overall T/TA and by local program people.

Similar results were obtained when analysis of other measures of T/TA effect, i.e., the key characteristics described in E2 (complete, practical, informative, timely) was undertaken.

IV. RECOMMENDATIONS

Up to this point in this Final Report, KAI has presented the data collected on T/TA and isolated for the benefit of the reader the salient findings and conclusions that surfaced in the data. The thrust of our efforts in Chapter III was to be objective; i.e., to display the data and let it speak for itself. In this Chapter, we are presenting for consideration by OCD officials some pertinent recommendations we believe can justifiably be made in light of the findings and conclusions. These recommendations are subjective on our part and may not be the same ones other readers of the data would make. We offer them, however, as interpretive judgments which OCD can consider in determining their future T/TA management activities.

First, there is much about which Project Head Start should be elated. For example, its local programs (judging by our sample) seem to be doing a phenomenal job of getting T/TA services donated by their community resources. This finding suggests a very strong impact has been made by local programs on their communities (as was verified by KAI five years ago in its National Survey of the Impacts of Head Start Centers on Community Insitutions) and that a very positive and cooperative relationship exists between grantees and community resources.

Second, regional providers of T/TA as a group (again, judging by our sample) seem to be well coordinated and delivering T/TA that is quite excellent. Discounting the fact that part of the basis for saying this is the testimony of regional providers themselves, it still can be stated that the regional-level providers tended to compare very favorably to the national and local ones in terms of how they were managed, how they delivered T/TA and the excellence of the final product. This finding is one for which, no doubt, both the National and Regional Offices deserve a share of the credit. In spite of all the friction over the past several years regarding Regional T/TA Plans demanded by the Headquarters, the end result apparently has been a good one.

The recommendations set forth here will follow the basic topical format of Chapter III on Findings and Conclusions.

M1. Regarding the setting of national objectives it seems imperative that OCD HQ devise a mechanism that "institutionalizes" or makes more formal the processes for gathering input on and setting up annual objectives. This mechanism should then be articulated to both national and regional level personnel so that they know exactly how to feed into the process if they so desire. Further refining and articulation of the mechanism should take place in order to maximize local level input. This will ultimately aid the entire T/TA system, even though the impact of such a recommendation obviously transcends T/TA matters.

M2. Numerous policy and guidance issues were mentioned as needing updating or initial attention. Granted, much has been accomplished in the past several years for which OCD HQ deserves enormous credit, but much still remains to be done. The Revised Head Start Manual seems to be grossly overdue; its publication would presumably resolve many questions that currently are unanswered. Failing the publication of the Manual in the near future, another solution to the problem of needed policies would be individual issuances on the most pressing subjects.

On the subject of the Annual Regional T/TA plan mandated by OCD Headquarters, many problems cited by the Regional Offices, e.g., a new format every year, too much information required, etc., apparently have been alleviated as a result of the FY 76 policy issuance. It still remains to be seen; however, whether the current policy will function well over a period of years or whether it will become outmoded next year and need refinement or replacement. This uncertainty seems reasonable given the fact that Project Head Start is really only beginning the process of decentralizing its T/TA program and the transition period is bound to be one filled with tension. The current tension seems to be not entirely a bad thing, in as much as there is abundant evidence that the T/TA being delivered by the regional providers as a consequence of the Regional T/TA Plans is quite effective. Therefore our recommendation would be not to discount the value of the T/TA planning processes that have been carried out by the regions over the past several years in compliance with National Office mandates. The national OCD ought to pursue even more diligently

a balance that allows the OCD Headquarters to coordinate all T/TA in accord with established goals and objectives, and, at the same time, enables each individual Region to plan its own T/TA program with the maximum amount of autonomy.

M3. As far as needs assessment and T/TA planning is concerned, it seems that the National office should reconsider its role in these matters. Is its role only secondary or after-the-fact as many central office staff maintained? What needs are being addressed when national providers are hired? On what basis have those needs been determined? Why do national providers tend to feel much more involved in these needs assessment and T/TA planning processes than do OCD officials? Even if OCD's role is to be only secondary, i.e., to collect data gathered at the regional and local levels, what mechanisms does it have in place to integrate these data and make appropriate decisions for the total T/TA program based on the data? KAI would recommendthat these kinds of questions be addressed by OCD officials as it reconsiders its role in needs assessment and T/TA planning processes. KAI would also recommend that a comprehensive Management Information System (MIS) be considered as one possible mechanism to aid in the overall tasks of needs assessment and T/TA planning.

There appears to be concurrence at both the regional and local levels among program personnel and providers as to what their roles are vis-a-vis needs assessment and how well those roles are being fulfilled. What remains to be done, however, is to refine and perfect the tools used for the assessing of needs. Apparently a number of excellent assessment tools are available, such as those, among others, in Regions II, IV, and X. But whether or not they are all readily available to interested parties is dubious. Even if the various tools were used only as guidance resources, a wider distribution of them would be very beneficial.

M4. Provider selection is a process that needs regular reexamination to prevent complacency among Head Start staff regarding the providers they are utilizing to deliver T/TA. Constant refining and improving of the criteria

followed for selection purposes and continual building of safeguards to preserve a process that encourages the choosing of providers most able to meet the specific needs of a given consumer group are two obvious things that can be recommended in this area.

Local level respondents seemed woefully unaware (70% of them) of the procedures followed by their Regional Offices in selecting providers to serve their region. It would seem advantageous for the Regional Offices to not only apprise their locals of their provider selection procedures, but also to invite them to participate in them as appropriate. Recall that a positive relationship was found to exist between familiarity with the regional selection processes and overall satisfaction with T/TA.

M5. The essential recommendation regarding provider control is serious consideration of a comprehensive management information system that would integrate data on all facets of the T/TA program at the national, regional, and local levels. Such a system would provide for retrieval of data at any given time to meet a multitude of needs, from satisfying Congressional information requests to preparing for the formulation of national Head Start objectives; from the coordinating of needs assessment and T/TA planning activities at the national, regional and local levels to the tracking of monitoring, reporting, and evaluation results from various T/TA activities.

This recommendation need not lead back to centralized control of the nearly $20 million annual T/TA budget at OCD Headquarters. On the contrary, it would enable the central office to coordinate the total T/TA program more effectively, the regions to continue to plan and implement their own T/TA programs autonomously, and the locals to operate more efficiently.

Another recommendation on this topic is that OCD HQ devise a more coordinated system for control of the national providers. Steps in the direction of a better system might well include more standard reporting and evaluation mechanisms for project officers who act as liaison to national providers, and better integration of efforts carried out by separate divisions, e.g., PD&I, CDTA, PMD, in relation to national provider control.

M6. Concerning evaluation of T/TA, our basic recommendation is to do more of it. Granted, this effort would require time and money, however, additional evaluation would force the T/TA managers, providers and recipients to be more concerned about the impact of T/TA.

At the national level there appears to be no uniform system for a) evaluating national providers; or b) collecting evaluation data on regional and local providers. We suggest that responsibility in the central office for both these activities be assigned clearly. Those responsible should devise adequate policy and guidance covering evaluation procedures and then articulate those procedures effectively to the involved personnel at the national, regional, and local levels.

D1. Regarding satisfaction with T/TA dollars, all categories of respondents manifested considerable dissatisfaction. There are valid reasons for this. Our study uncovered strong data showing that certain target groups are not getting sufficient T/TA and that specific content areas are not being adequately addressed. Accordingly we recommend that OCD officials give consideration to possible ways to provide additional financial support for the Head Start T/TA program.

D2. On the topic of utilization of resources in matters relating to T/TA, KAI's study uncovered evidence of strengths in all facets of the delivery system employed by national, regional, state, and local Head Start personnel. Therefore, we do not intend to recommend that any one piece of the overall delivery system be scuttled. On the contrary, the various national, regional, state, and local T/TA resources on the whole serve discrete and valid functions and tend to complement one another.

Our finding on this topic of resource utilization should be reiterated here: the closer the source of T/TA is to the local level, the greater the satisfaction with overall T/TA by local program people. This finding leads us to recommend that OCD continue to provide mechanisms, such as direct-funding, which will enable local programs to have effective access to T/TA resources.

Still another finding of note was that local programs sampled seem to have a good balance of T/TA services from national, regional, state, local, and non-Head Start resources. We cite this as further buttressing for our suggestion that all levels of the overall T/TA delivery system for Project Head Start be maintained. However too much emphasis on any one resource, to the extent that other T/TA resources are minimized, does not at all seem justified according to our data.

D3. As mentioned in the introduction to his chapter local programs apparently are doing a phenomenal job of getting T/TA services donated by supportive resources, such as their community agencies and organizations. We recommend that OCD officials look into this phenomenon further and investigate possible ways to further capitalize on the apparent rapport existing at the local level between the grantees and their communities.

Our data on this topic also showed that local Head Start programs are receiving substantial help in T/TA matters from the parents of enrolled children. We therefore recommend that OCD officials also look for additional ways to capitalize on the resources of parents - a suggestion certainly in line with Head Start's committment to parent involvement.

D4. In regard to the topic of target grouns, parents are again the appropriate focus of dicussion, because they ranked first as a category of persons in need of additional T/TA. They were followed, in order, by coordinators and administrators. All target groups moreover (i.e., the above three, plus teachers, aides, and support staff) were clearly perceived by our respondents to need additional T/TA; no target group was reported to need less T/TA. Therefore we recommend that Head Start officials and staff work to devise ways to improve the coverage of T/TA across all appropriate target groups.

D5. Regarding content categories of T/TA KAI collected data showing that the most frequently offered categories were education, parent involvement,

handicapped services, and performance standards. We also found that handicapped services T/TA was most frequently mentioned as an inadequately covered category, indicating that even though it is a subject being addressed nightly, it still needs further emphasis. Other content categories mentioned often as being either totally overlooked or inadequately covered were management and administration, parent education (which parallels the finding cited earlier about parents as a target group needing more T/TA), health services, social services, interpersonal or group dynamics, performance standards, and child development/psychology. We recommend to OCD, as a result, that appropriate steps be taken to fill these gaps in T/TA content categories.

D6. So far as special categories of T/TA are concerned, i.e., nutrition, psychological services and handicapped, KAI gave special emphasis to these in response to suggestions from OCD HQ officials. The data indicate that a high need exists for T/TA in these three special areas and that the need is, comparatively, most for handicapped (which parallels the finding cited in the previous section) next for psychological services, and last for nutrition services. One-half to one-third of our sample perceived their needs as high in each of these three special categories. Accordingly KAI recommends to OCD that an effort be made to fill these special unmet needs.

E1. E2. Data from the topics relating to T/TA excellence (quality and impact) have been used to support recommendations made about the T/TA management and delivery systems. No specific recommendations on these topics will be made.

DF. On the topic of direct funding of local programs to purchase their own T/TA, KAI's study uncovered strong evidence showing a positive relationship between direct-funding and perceived impact of overall T/TA. This finding indicates it has been very effective. Any decision to expand the practice of direct-funding, however, necessarily must take into consideration other issues, some of which have been touched on in this evaluation and some of which have not.

A local grantee must have the capacity both to assess needs and to plan for a T/TA program. It must further possess commensurate skills in other areas of T/TA management. It must, for example, be able to identify and recruit appropriate T/TA resources that fit its financial framework and fulfill its T/TA needs. The implication here is that grantees will always need more T/TA than is available to them via direct-funding. Grantees must be able to depend upon state, regional and national resources for T/TA services.

It is also safe to assume that in some cases direct-funding for purchase of T/TA is not going to be the most cost-efficient. This situation would likely exist in rural areas or with regard to highly specialized forms of T/TA. In cases such as these, a broader state and/or regional system seems appropriate. Hence KAI recommends that OCD retain the direct-funding mechanism as a valid and viable option for delivering T/TA but be judicious in the selecting of the option.

Lastly, we have a recommendation on the dissemination of this Final Report. Since this document contains, but does not isolate for ease of review, much data on strengths and weaknesses of the seven case study regions, we suggest that a series of subsidiary reports be prepared, one for each individual case study region, utilizing data contained in this Report that is presently organized by topic and not by region. This dissemination procedure would help the regional office staff focus on the findings directly relevant to their operation. We also suggest that ways be considered to disseminate the results of this study to the local program level as well.